TELECOMMUNICATION VERSION 5 QUESTIONS, ANSWERS AND EDITORIAL UPDATES

DOCUMENTATION

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Telecommunication Version 5 Questions, Answers and Editorial Updates

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PURPOSE OF THIS DOCUMENT

This document provides a consolidated reference point for questions that have been posed based on the review and implementation of the NCPDP Telecommunication Standard, Implementation Guide, and Data Dictionary for Version 5. This document also addresses editorial changes made to these documents.

As members reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. These questions were addressed in the Work Group 1 Telecommunication meetings. The question and answer was then posted on the web site under the heading of the various work group session. As questions occurred during several Work Group sessions, it was requested that the questions be consolidated for easier reference. This document consolidates those questions and answers under reference categories.

The categories provide a high level reference for the topic. For example, a category may be a Segment in the format, with a subcategory of a field in that segment. The question and answer is then posed for that field found in that segment. Where appropriate, the question may be the actual heading in the index for ease of research.

Editorial changes include typographical errors, comments that do not match a field value, a reference pointer in error.

NCPDP Telecommunication Standard Version 5.1 was named in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As of October 2ØØØ, Version 5.1 documents are frozen for changes until the Change Request System (CRS) is implemented by the Designated Standards Maintenance Organizations (DSMOs) and the Department of Health and Human Service (DHHS). Editorial or clarification changes, as well as format changes cannot be made to the Version 5.1 documents until put through the change process.

However, NCPDP may make editorial changes to the Version 5.Ø and Version 5.2 and above documents when deemed necessary by the members. These editorial changes are helpful to the implementation of the standard. Many of the changes apply to all the Version 5 and above documents.

To avoid confusion of questions or changes which have been posed in the Version 5.Ø and/or Version 5.2 and above documents, but which are not reflected in the frozen Version 5.1 documents, this reference guide should be used.

This document will continue to be updated as questions and answers or editorial changes are necessary.

Note: within the guide, when dollar fields and amounts are discussed, all digits may be seen for readability. When actually using the field, rules should be followed for the overpunch character, as applicable.

USE OF THIS DOCUMENT

This document should be used as a reference for the Telecommunication Standard Version 5.1 and the Batch Standard Version 1.1. In the Batch Standard format, the Detail Data Record consists of the NCPDP Data Record, which consists of the Telecommunication Standard record format. Therefore references in this document apply to both standards.

REQUEST SEGMENT DISCUSSION

TRANSACTION HEADER SEGMENT

SOFTWARE VENDOR/CERTIFICATION ID (11Ø-AK)

USAGE

Question:
How is Transaction header field 11Ø-AK used?

Response:
This field is used by some processors who certify vendor software before allowing access to their systems. Each payer should publish a provider manual or payer sheet that shows their requirements. One requirement may be certification testing. The field may be populated with an ID per vendor, or per a "chain" or may not be used and therefore space filled.

TRANSACTION COUNT (1Ø9-A9)

USAGE

Question:
What is the intent of the new field Transaction Count (1Ø9-A9)?

Response:
This is a new field in Version 5. The definition of Transaction Count (1Ø9-A9) is "Count of transactions in the transmission". Dependent on the transaction type, this field indicates the number (maximum of 4) of transactions (e.g. claims, reversals, et cetera) within a transmission. In previous telecommunication standards, this information was communicated along with the transaction type in the "Transaction Code" field as a combined value.

TRANSACTION HEADER SEGMENT FIELDS NOT MODIFIED IN RESPONSE HEADER SEGMENT

See section "Response Header Segment Fields Not Modified From Transaction Header Segment", "Usage" for more information.

PATIENT SEGMENT

EMPLOYER ID (333-CZ)

USAGE

Question:
What is the intent of using Field 333-CZ Employer ID?

Response:
Employer ID (333-CZ) is a new telecommunication field. The definition is "ID assigned to employer" and the field is located in the Patient segment. The intent of supporting this field in our new telecommunication standard is to be prepared for any Health Insurance Portability and Accountability Act (HIPAA) requirements mandating the identification of the employer responsible for the patient's pharmacy benefits.

INSURANCE SEGMENT
CARDHOLDER ID (3Ø2-C2)

Question:
Can a cardholder ID contain symbols such as hyphens and apostrophes?

Response:
Yes, printable characters (including symbols) are allowed. Therefore, hyphens and apostrophes may be used. If punctuation characters are used, they must be easily readable to the provider trying to read the cardholder information for example, on a paper or plastic card.

The use of symbols, while a trading partner issue, can lead to confusion on the part of the provider unless they match exactly to information on the member or patient's card. Use of certain symbols may cause problems with the parsing routines in the system programs that must interpret them. Ultimately it will be the payer/processor who will determine the required format of the Cardholder ID field because they must be able to parse and interpret the field.

Please see section "Transmission/Transaction Syntax", "

FACILITY ID (336-8C)
ASSIGNATION/DEFINITION

Question:
Is the Facility ID (336-8C) replacing the Clinic ID (422-DM)?

Response:
Yes.

Question:
How will this field be assigned and who will assign it?

Response:
This field was renamed. It was previously called Clinic ID. Some organizations may assign an internal value. Some payers may assign a value. HIPAA regulations may ultimately determine how this field is used. HIPAA may require CMS to enumerate.

Question:
What is the purpose in a claim submission if a plan or processor requests it?

Response:
Current uses may include reporting, and Assignment of Benefits. May also tie a patient to a physical location.

Question:
What is meant by the definition of "Patient's Clinic/Host Party"?

Response:

The “Patient’s Clinic/Host Party” is intended to represent the primary physical location responsible for the patient’s medical care.

Question:
Depending on how this field is being used, can this Facility ID change each time a patient goes to a different clinic (e.g. could this be a frequently changing value?)?

Response:
Yes.

Question:
What are of the business requested the use of this field?

Response:
We do not recall the business party that requested this field.

Question:
Does the field Facility ID (336-8C) link to a patient and an insurance plan? Is this field in any way linked or associated with a prescriber? How do you see this field being used in the real world? How would an insurance plan utilize this field?

Response:
No, there is no standard link established between this field and a patient, insurance, or prescriber. This field is typically used to identify long-term or rest home facility. Currently, this is a trading partner issue on how it is used.

PLAN ID (524-FO)
USAGE

Question:
Can you explain briefly how this field is used and what is its purpose?

Response:
The definition of “Plan ID” is “Assigned by the processor to identify a set of parameters, benefit, or coverage criteria used to adjudicate a claim”. This is an optional field in both the Insurance Segment (request) and Response Insurance Segment.

In the Response Insurance Segment, we envision the payer using this field to communicate the “network” or “contract method” employed to pay the claim. In the Insurance Segment (request) we envision the provider using this field to communicate the expected “network” or “contract method” for which the claim should be reimbursed.

CLAIM SEGMENT
ALTERNATE ID (33Ø-CW)
HOW DOES A PHARMACIST KNOW WHO IS GOING TO PICK UP THE PRESCRIPTION?

Question:
“Alternate ID” is a field on the Request Claim segment. If this field is submitted with the prescription claim how does a pharmacist know who is going to pick up the prescription?

"Alternate ID" Definition:
Person Identifier to be used for controlled product reporting. Identifier may be that of the patient or the person picking up the prescription as required by the governing body.

Response:
"Alternate ID" supports the identification of either the patient or the person picking up the prescription. If "Alternate ID" is used to identify the person picking up the prescription it most likely will be used in the new Controlled Substance Reporting transaction. We envision the controlled substance reporting transaction occurring subsequent to the billing of the claim and post purchase. It is also possible that the "Alternate ID" could be used to identify the patient and submitted simultaneously with the prescription claim.

COORDINATION OF BENEFITS
OTHER COVERAGE CODE (3Ø8-C8)

Question:
For Coordination of Benefits (COB) processing - The Other Coverage Code (3Ø8-C8) is on the Claim Segment and is only available for one iteration even though there may be multiple iterations of detailed other payer info on the COB/Other Payments Segment. How does NCPDP propose to handle conditions when the Other Coverage Code reflect (e.g.) that for the primary payer the other coverage is not in effect on Date Of Service (4Ø1-D1), for the secondary payer the other coverage exists/payment collected; and for the tertiary payer the coverage is terminated? I am concerned about any combination of payers that might net different Other Coverage Code values if submitted on a single claim transaction.

Response:
The current values for Other Coverage Code (3Ø8-C8) are

Value	Description	Further Clarification
Ø1	No other coverage	
Ø2	Other coverage exists-payment collected	
Ø3	Other coverage exists- claim not covered	Patient has other coverage, but the prior payer (primary, secondary, tertiary) does not cover this product or service.
Ø4	Other coverage exists-payment not collected	Used in a payable response, when payment is zero with 100% co-payment.
Ø5	Managed care plan denial	The patient has managed care coverage, but the claim was denied.
Ø6	Other coverage denied-not participating provider	There is other coverage, but this provider (pharmacy) is not eligible.
Ø7	Other coverage exists-not in effect on Date of Service	The patient has other coverage, but at the time of service, the coverage was not in effect.
Ø8	Claim is billing for copay	Used in copay only billing, when the COB/Other Payment Segment is not submitted.

The word “payment” in these statements does not include any co-payment.

The COB/Other Payments Segment is used for secondary, tertiary, etc claims that have successfully adjudicated with a “P”aid (or “D”uplicate of Paid) or Rejected response from the previous payer(s). The COB/Other Payments Segment is not used when the primary payer “C”aptures the claim.

For the present time, we recommend the following.

- The processor should look for the COB/Other Payments Segment.
- If any of the loops of the COB/Other Payments Segment contain Other Payer Amount Paid (431-DV) greater than zero, the Other Coverage Code (3Ø8-C8) should be 2.
- If **none** of the loops of the COB/Other Payments Segment contain Other Payer Amount Paid (431-DV) greater than zero and one of the loops contains Other Payer Amount Paid (431-DV) of zero, the Other Coverage Code (3Ø8-C8) should be 4.
- If **all** of the loops of the COB/Other Payments Segment contain rejection information, the Other Coverage Code (3Ø8-C8) will not contain 2 or 4. In the rejection information, the NCPDP Reject Codes (511-FB) will further explain the reason for rejection.

Further

- If the Other Coverage Code (3Ø8-C8) is 0 or 1 or 8, the COB/Other Payments Segment does not exist.
- If the Other Coverage Code (3Ø8-C8) is 2, the COB/Other Payments Segment is present and at least one of the loops will contain Other Payer Amount Paid (431-DV) greater than zero.
- If the Other Coverage Code (3Ø8-C8) is 3 through 7, the COB/Other Payments Segments may exist and the loops should be interrogated for further information.

Third Occurrence Usage for More than Four Coverages in COB:
Currently in COB where there are more than three **other** payers, the third occurrence must be a composite of the third and higher payers.

For example, when submitting to the fifth payer, to report the information from payer one through payer four, the following is recommended (not all fields shown).

Field ID and Name	Value	Description
When submitting to the third payer, the first occurrence contains the primary (Ø1). The second occurrence contains the secondary (Ø2).		
Other Payer Coverage Type (338-5C)	Ø1	Primary
Other Payer Amount Paid Qualifier (342-HC)	Ø4	Administrative
Other Payer Coverage Type (338-5C)	Ø2	Secondary
Other Payer Amount Paid Qualifier (342-HC)	Ø3	Postage
When submitting to the fourth payer, the first occurrence contains the primary (Ø1). The second occurrence contains		

the secondary (Ø2). The third occurrence contains the tertiary payer (Ø3).		
Other Payer Coverage Type (338-5C)	Ø1	Primary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	Ø2	Secondary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	Ø3	Tertiary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
When submitting to the fifth payer, the first occurrence contains the primary (Ø1). The second occurrence contains the secondary (Ø2). The third occurrence MUST CONTAIN the composite (99) and sum of all reimbursement (Ø8) of the tertiary and fourth payer.		
Other Payer Coverage Type (338-5C)	Ø1	Primary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	Ø2	Secondary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	99	Composite
Other Payer Amount Paid Qualifier (342-HC)	Ø8	Sum of all reimbursement

If **any** payment has been received from any number of payers
- Other Coverage Code (3Ø8-C8) is 2

If **no** payment has been received from any number of payers
- Other Coverage Code (3Ø8-C8) is 3 or 4

A Data Element Request Form (DERF) will be submitted in the future to address this business need.

USAGE

Please see “Appendix B. Coordination Of Benefits Explanation For Version 5.1” for information on billing COB in Version 5.1.

DATE OF SERVICE (4Ø1-D1)
VALUE RETURNED ON COMPLETION FILLS

Question:
What is the date of service that will be returned on remittance detail for a "C" Completion transaction? Will it be the Date of Service (4Ø1-D1) or Associated Prescription/Service Date (457-EP)? Hopefully it will be the Date of Service (4Ø1-D1) to avoid claims appearing as duplicates.

Response:
It is our recommendation that the value in the "Date of Service" field 4Ø1-D1 on the response match the value in the "Date of Service" field on the inquiry field.

Dispensing Status	RX Number	Inquiry Date of Service	Transaction Submission Date	Response Date of Service
"Partial"	1234567	Ø4/2Ø/ØØ	Ø4/2Ø/ØØ	Ø4/2Ø/ØØ
"Completion"	1234567	Ø4/21/ØØ	Ø4/21/ØØ	Ø4/21/ØØ
"Completion"	1234567	Ø4/21/ØØ	Ø4/22/ØØ	?

RELATIONSHIP TO MEASUREMENT DATE

Question:
Is there a relationship between the claim date of service (4Ø1-D1) and the measurement date (494-ZE)? Does the measurement date need to be equal to or less than the claim date of service?

Response:
The "Date of Service" (4Ø1-D1) field "Identifies date the prescription was filled or professional service rendered." The "Measurement Date" (494-ZE) is the "Date clinical information was collected or measured." The Date of Service may be the date the pharmacist counseled a patient. However, the clinical data may have been measured/collected on a prior or later date.

DISCHARGE DATE SUPPORT
USAGE

A business need was brought forward to support a Discharge Date in the Telecommunication Standard Version 5.1 environment. Since new fields could not be added to the already approved and HIPAA-named Telecommunication Standard Version 5.1, the membership approved the short-term use of the Prior Authorization Number Submitted (462-EV).

The Discharge Date, in the format of CCYYMMDD may be included in this field. Under Version 5.1 rules, when the Prior Authorization Number Submitted (462-EV) is submitted, the Prior Authorization Type Code (461-EU) must be populated. (This restriction was removed in Version 7.Ø.) It is recommended that the value of 8=Payer Defined Exemption is used when Discharge Date is supported.

It is recommended that payers that need the Discharge Date clearly define the usage in their payer sheet/provider manual. Clarification should be given if a payer needs to support both a prior authorization number AND a discharge date in this field.

FILL NUMBER (4Ø3-D3)
DEFAULT?

Question:
Field 4Ø3-D3, Fill Number, is defined as a numeric field. Per the data dictionary the values defined for this field are Ø = Original fill, 1-99 = refill number. Since this field is a numeric field, the default value is zero. According to the recommendations in the standard and implementation guides for field truncation, if an optional field contains its default value, the sender may omit the field entirely. My question is, per the standard, would it be appropriate to omit sending the Fill Number, since it is an optional field, when the transaction is for the original fill? Would it be reasonable for a processor to assume, since the field has not been submitted, that the transaction was for the original dispense?

Response:
Because Ø is a codified value, not a default value, if the processor requires submission of the Fill Number, it is not appropriate to omit it.

FILL NUMBER BE THE SAME FOR PARTIAL AND COMPLETION FILLS

Question:
Why is it recommended that the fill number (field 4Ø3-D3) for a “C” Completion transaction be the same as for the “P” Partial fill transaction? Since the “C” Completion transaction must indicate the Associated Prescription/Service Reference Number (456-EN) as well as Associated Prescription/Service Date (457-EP) isn’t that enough to match the “C” Completion transaction to the previous “P” Partial fill transaction?

Response:
Field 4Ø3-D3 is the Fill Number. The “Fill Number” is defined as “Code indicating whether the prescription is an original or a refill”. In a vast majority of cases your point is well taken. However, the recommendation to match the “Fill Number” on corresponding “C” Completion and “P” Partial fill transactions results from a business need to ensure accurate matching in the instance in which two prescriptions with the same Associated Prescription/Service Reference Number and Associated Prescription/Service Date occur.

INTERMEDIARY AUTHORIZATION ID (464-EX) AND INTERMEDIARY AUTHORIZATION TYPE ID (463-EW)
EXPLAIN DIFFERENCE WITH PRIOR AUTHORIZATION

Question:
If this is used internally in order to override an edit, how is this used differently from a Prior Authorization?

Response:
The definition of “Intermediary Authorization ID” is “Value indicating intermediary authorization occurred”.

The definition of “Intermediary Authorization Type ID” is “Value indicating that authorization occurred for intermediary processing”.

In Version 3.2, the Prior Authorization fields are used for two purposes, specific help desk phone call requests to alter a claim's adjudication, and to proactively allow the Pharmacist to transmit a predefined standard value to bypass a specific reject, i.e. DUR reject.

In Version 5, these two uses are broken into separate fields. Intermediary Authorization ID/Type fulfills the latter need, thereby allowing the Prior Authorization fields to be used only for the former.

Example:
Today the standing Prior Authorization value of "9991234" may override any DUR edit reject. The same value is used for all patients and drugs. In Version 5, the Pharmacist places this value in the new Intermediary fields allowing specific patient drug related Prior Authorization values to be placed in the Prior Authorization fields.

A SPECIFIC EXAMPLE

Question:
Can you explain a specific instance or example?

Response:
Here is an example. An intermediary authorization system identifies a non-formulary NDC number on a claim submission. The intermediary rejects the claim with a drug formulary message. The pharmacist overrides the claim with an appropriate entry in the Intermediary Authorization Number field to indicate a desire to submit the prescription with the existing drug submission and therefore override the editing system.

PROCEDURE MODIFIER CODE (459-ER)

PROCEDURE MODIFIER CODE AND NDC

Question:
From a standards perspective is it valid to require the reporting of procedure code modifier(s) with national drug codes?

> Our customer recently began to apply Medicare Part B entitlement editing against incoming pharmacy claims submitted with national drug codes. When the Part B entitlement is detected, the claim is paid to the pharmacy and the TPL agent for the State reformats the claim into a professional claim and submits the claim under a HCPCS code to Medicare. Medicare will be requiring that these claims be submitted with specific procedure code modifiers before the DMERC Carrier can consider the claim for payment. There are situations where a modifier may/will be necessary for DMERCs to properly process a claim with an NDC code (ie: nebulizer drugs where the KO would be required, waiver of liability modifiers, to name a few cases). Our customer wants us to collect the procedure code modifiers on the initial claim submission so that the procedure code modifiers are available in the event the claim is submitted to Medicare subsequent to payment. These claims are for services rendered to enrollees in State prescription drug programs.

Response:

The standard does not prohibit the reporting of procedure code modifier(s) with National Drug Codes (NDC).

WHERE DO I OBTAIN A PROCEDURE MODIFIER CODE LIST?

Question:
"Procedure Modifier Code" is a new field with the definition "Identifies special circumstances related to the performance of the service." The Data Dictionary references HCFA (CMS). Whom do I contact to obtain this information?

Response:
The "Procedure Modifier Codes" are located in the HCPCS section of the HCFA (CMS) website. The web site address is: http://www.hcfa.gov/stats/pufiles.htm#alphanu.
This will take you to the alpha numeric HCPCS files section that contains all of the codes.

PRODUCT/SERVICE ID (4Ø7-D7)
FORMAT AND USAGE

Question:
By business partner agreement, a pharmacy wishes to submit Workers' Compensation claims to its billing services provider using the NCPDP Telecom v7.Ø Standard. (This should not need to comply with HIPAA regulations for transaction and code sets.) This is an update to the existing process that currently utilizes RTDS 3B of the NCPDP Telecom v3.2 Standard. The current process uses NDC Number (field 4Ø7-D7) to carry UPC and HRI codes in an 11-digit format. The v5.Ø and subsequent Standard releases have renamed and restructured the field (now Product/Service ID, 11 digits to 19 characters) and include a qualifier for the field, Product/Service ID Qualifier (436-E1). Now that the qualifier is available, should the UPC and HRI values be sent in their native format instead of being reformatted to an 11-digit value?

Response:
For current usage, the 11-digit format should remain the same and be used for UPC (value "Ø1"), HRI (value "Ø2"), and NDC (value "Ø3") qualifier values. If there is a need to utilize the native format of these identifiers, a Data Element Request Form (DERF) should be submitted for the development of a new qualifier.

SCHEDULED PRESCRIPTION ID NUMBER (454-EK)
IS THIS FIELD ONLY FOR CONTROLLED SUBSTANCE REPORTING TRANSACTIONS?

Question:
Is this field "only" used for Controlled Substance Reporting (C1) Transactions or can it be present on a Claim or Service Billing (B1) Transaction?

Response:
The definition of "Scheduled Prescription ID Number" is "The serial number of the prescription blank/form". This field is primarily intended to be used on a Controlled Substance Reporting (C1) or Controlled Substance Reporting Rebill (C3) transaction. It may also be submitted on a Billing (B1) transaction.

SUBMISSION CLARIFICATION CODE (42Ø-DK)
SUBMISSION CLARIFICATION COUNT (354-NX)

Question:
What Reject Code (511-FB) should be used when the Submission Clarification Code (42Ø-DK) doesn't match the number submitted in the Submission Clarification Code Count (354-NX)?

Response:
Thank you for bringing this to our attention. Submission Clarification Code Count (354-NX) was added in Telecommunication Standard Version 7.Ø. The Reject Code (511-FB) for "Submission Clarification Code Count Does Not Match Number of Repetitions" was mistakenly not included. We will make sure this is added to a future version. For now, Reject Code (511-FB) "NX" "M/I Submission Clarification Code Count" should be used.

VALUE 9 ENCOUNTER USAGE

Question:
In the Claim Segment field 42Ø-DK, code 9: is this used for encounter data from providers in a managed care network? If not, what is the purpose of this code?

Response:
It is used to designate the transaction is an encounter versus fee for service.

COB/OTHER PAYMENTS SEGMENT
COORDINATION OF BENEFITS
USAGE

Please see "Appendix B. Coordination Of Benefits Explanation For Version 5.1" for information on billing COB in Version 5.1.

OTHER PAYER AMOUNT PAID COUNT (341-HB)
REJECT CODE WHEN COUNT DOES NOT MATCH

Question:
What Reject Code (511-FB) should be used when the Other Payer Amount Paid (431-DV) doesn't match the number submitted in the Other Payer Amount Paid Count (341-HB)?

Response:
Thank you for bringing this to our attention. Reject Code for "Other Payer Amount Paid Count Does Not Match Number Of Repetitions" was mistakenly not included. We will make sure this is added to a future version. For now, Reject Code "HB" "M/I Other Payer Amount Paid Count" should be used.

OTHER PAYER AMOUNT PAID COUNT AND OTHER PAYER REJECT COUNT FOR THE SAME OTHER PAYER

Question:
What if' 'Other Payer Amount Paid Count' and 'Other Payer Reject Count' and corresponding fields were submitted for the same 'Other Payer'? The imp guide says either one or the other would be sent, I assume not both. If both are sent what would the suggested returned error be, R8 Syntax Error or M/I error for both fields?

Response:
Yes - that is correct - one or the other, but not both for each loop. The M/I reject codes and any other appropriate reject codes should be sent. The Additional Message (526-FQ) can also be used to relay that the provider system should submit paid or reject information on each loop, but not both. The R8 Syntax Error should not be sent by itself without qualification.

NEGATIVE AMOUNTS

Question:
Would it be possible for a negative amount (less than zero) to be entered in 'Other Payer Amount Paid' on the claim submit? If so, and the payer will not accept negative amounts, would the M/I error for that field be applicable?

Response:
Yes - all the dollar amounts are signed fields so it is possible to use negative amounts. In some cases, a negative dollar might not be applicable to the business case, but the sign is still supported. The covered entities need to be able to support the sending/receiving of negative dollar amounts, per the standards. The transaction should not be rejected syntactically because a negative amount is sent, although the claim could be rejected based on business rules.

OTHER PAYER ID (34Ø-7C)
ENUMERATION

Question:
What is the source of the values submitted in the Other Payer ID Qualifier (field 339-6C) and Other Payer ID (field 34Ø-7C)?

Response:
“Other Payer ID” is the “ID assigned to the payer”. “Other Payer ID Qualifier” is the “Code qualifying the “Other Payer ID””. Both fields are in the COB/Other Payments Segment. “Other Payer ID Qualifier” indicates the defined code values that may be used in this field. These code values are associated with national agencies responsible for enumerating the payers. So, the number that is assigned to the payer is sent in field 34Ø-7C (Other Payer ID), and the code corresponding to the enumerating agency is sent in field 339-6C (Other Payer ID Qualifier).

OTHER PAYER COVERAGE TYPE (338-5C) = “99” (COMPOSITE) AND OTHER PAYER ID (34Ø-7C)

Question:
When the value 99=composite is used in the Other Payer Coverage Type, what is placed in the Other Payer ID? Is it not sent?

Response:
The Other Payer ID Qualifier (339-6C) and Other Payer ID (34Ø-7C) must not be sent when Other Payer Coverage Type (338-5C) is 99 (Composite).

SAME OTHER PAYER ID (34Ø-7C) IN DIFFERENT COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT (337-4C) OCCURRENCES

Question:
The recommended COB/Payments Count is (3). What if two or more of these occurs had the same Other Payer ID but different values, either both paid or both rejects or combination? If two or more occurs of the same Other Payer ID should not be sent, what would the suggested error be, syntax or M/I with the Reject Field Occurrence Indicator?

Response:
The recommended maximum amount of the COB/Payments Count is 3. The count of 2 or 3 instances of the same Other Payer ID could occur under different scenarios. Two examples might include the following. One might be that it is possible that a payer may allow themselves to be billed as a primary and secondary, or a secondary and tertiary, or a primary and tertiary (meaning multiple times for the same claim). Another might be if there are three payers and two of these payers use the same processor (for example the same BIN number might be sent for two different payers). If however, due to trading partner determination, a payer does not allow this type of scenario, then the appropriate M/I Reject Codes with the Reject Field Occurrence Indicator (546-4F) should be used. The R8 Syntax Error should not be sent by itself without qualification.

Based on the Other Coverage Code question (see section “Request Segment Discussion”, subsection “Claim Segment”, subsection “Coordination of Benefits”, subsection “Other Coverage Code 3Ø8-C8”), it is recommended that if there are more than three payers, the third occurrence be a composite of the third and higher occurrences.

OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT CODE (352-NQ) AND QUALIFIER (351-NP)
Question:
What Reject Code (511-FB) should be used when the Other Payer-Patient Responsibility Amount (352-NQ) and Qualifier (351-NP) doesn’t match the number submitted in the Other Payer-Patient Responsibility Amount Count (353-NR)?

Response:
Thank you for bringing this to our attention. Other Payer-Patient Responsibility Amount (352-NQ) and Qualifier (351-NP) were added in Telecommunication Standard Version 5.5. The Reject Code for “Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions” was mistakenly not included. We will make sure this is added to a future version. For now, Reject Code (511-FB) “NR” “M/I Other Payer-Patient Responsibility Amount Count” should be used.

DUR/PPS SEGMENT

CLAIM VERSUS SERVICE BILLING

USAGE

Question:
What differentiates when a DUR/PPS Segment is submitted with an Rx billing (Prescription/Service Reference Number Qualifier = 1) and when the DUR/PPS Segment is submitted as a separate transaction (Prescription/Service Reference Number Qualifier = 2)? Is it based on whether a Professional Service Fee (477-BE) is submitted?

Response:
A "2" in the "Prescription/Service Reference Number Qualifier" field indicates the submission of a pharmacy claim for a "service" without the dispensing of a product. A "1" in the "Prescription/Service Reference Number Qualifier" field indicates the submission of a pharmacy claim for a dispensing. This may, or may not, include the communication of DUR/PPS Segment information and the submission of a Professional Service Fee Submitted. Therefore a "1" could be a billing for a "Product Dispensing" or a "Product Dispensing/Service combination. See section 4.2 in Version 5 Implementation Guide.

PRICING SEGMENT

COORDINATION OF BENEFITS

USAGE

Please see "Appendix B. Coordination Of Benefits Explanation For Version 5.1" for information on billing COB in Version 5.1.

SALES TAX FIELDS

FORMAT

Question:
How is the format of Percentage Sales Tax Rate Submitted (483-HE) and Percentage Sales Tax Rate Paid (56Ø-AY) expressed?

Response:
These fields are defined as s9(3)v4 allowing values of . ØØØ1% through 1ØØ.ØØØØ%. For the purposes of this example, the overpunch character is shown.

Examples:

A rate of:	**Spelled out:**	**Would be expressed as (without truncation):**	**Would be expressed as (with truncation):**
. ØØØ1%	one ten thousandth of a percent	ØØØØØØA	A
7%	seven percent	ØØ7ØØØ{	7ØØØ{
.5%	five tenths of a percent	ØØØ5ØØ{	5ØØ{
25.75%	twenty five and seventy five one hundredths of a	Ø2575Ø{	2575Ø{

	percent		
1ØØ%	One hundred percent	1ØØØØØ{	1ØØØØØ{

Seven percent (7%) would not be represented as 7Ø{ (.Ø7Ø{).
Note the difference between the expression of .ØØØ1% and 1ØØ%. They are very different expressions and should not be confused.

USAGE

Question:
How are the Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Percentage Sales Tax Rate Submitted (483-HE), and Percentage Sales Tax Basis Submitted (484-JE) used?

Response:
The submission of sales tax is governed by regulatory agencies (state, local, parish, etc).

Note that if a flat rate is needed, for example for administrative costs, the Other Amount Claimed Submitted Count (478-H7), Other Amount Claimed Submitted Qualifier (479-H8), and Other Amount Claimed Submitted (48Ø-H9) should be used. The Other Amount Claimed Submitted Qualifier field contains values for shipping, administrative, delivery, postage, and other costs.

If the sales tax reported is a flat rate, then it is a fixed amount for a certain dollar value (for example for $xxx it is a certain amount). For example, for $1ØØ the flat rate is $1.99. This flat rate is then reported in Flat Sales Tax Amount Submitted (481-HA).

If the sales tax reported is based on a percentage (for example 8.35%, 6.25%), the calculated amount is reported in Percentage Sales Tax Amount Submitted (482-GE). The Percentage Sales Tax Rate Submitted (483-HE) reports the percentage used (8.35%). The Percentage sales Tax Basis Submitted (484-JE) reports on what amount the taxes were calculated (Gross Amount Due, Ingredient Cost, Ingredient Cost plus Dispensing Fee).

In cases where a pharmacy needs to report sales tax based on a flat amount **and** a percentage amount, the Standard does support this usage.

USUAL AND CUSTOMARY CHARGE (426-DQ) DEFINITION
USAGE

Question:
Does Usual And Customary Charge (426-DQ) include a dispensing fee? The definition is "Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed." We weren't sure if the "other amounts claimed" referred to field 48Ø-H9, Other Amount Claimed Submitted, or just as a general term.

Response:
The Usual and Customary Charge (426-DQ) represents the value that a pharmacist is willing to accept as their total reimbursement for dispensing the product/service to a cash-paying customer. It does not include Other Amount Claimed Submitted (48Ø-H9),

Dispensing Fee Submitted (412-DC), Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Professional Service Fee Submitted (477-BE), or Incentive Amount Submitted (438-E3). U&C is independent of contracted Dispensing Fee Submitted (412-DC) and Ingredient Cost Submitted (4Ø9-D9).

PRIOR AUTHORIZATION SEGMENT

AUTHORIZED REPRESENTATIVE FIRST NAME (498-PE) AND AUTHORIZED REPRESENTATIVE LAST NAME (498-PF)

USAGE

Question:
Can you briefly explain how these fields are used?
Is this representative of a person who is a “Power of Attorney” if the patient is in a nursing home?

Response:
The definition of “Authorized Representative First Name” is “First name of the patient’s authorized representative”. The definition of “Authorized Representative Last Name” is “Last name of the patient’s authorized representative”. Both fields are used in the Prior Authorization (request) segment. These fields are used to identify the name of the person who may have Power of Attorney, a legal guardian, or a court appointed representative for an individual. It may or may not be a representative of a patient in a nursing home.

COUPON SEGMENT

COUPON NUMBER (486-ME)

USAGE

Question:
What is the new Coupon Number (486-ME)? Is the intent simply to start billing on-line manufacturer’s medication coupons?

Response:
Field 486-ME Coupon Number is used to communicate the unique number assigned to a coupon to the processor/payer. The coupon number supports the processor’s ability to uniquely track and process the economic value of an individual coupon. We envision the coupons being supported by the manufacturers.

CLINICAL SEGMENT

EXPLICIT DECIMAL POINTS IN DIAGNOSIS CODE (424-DO)

Question:
In V5.1, when submitting an ICD-9 code in field Diagnosis Code (424-DO), must a decimal point always be submitted with the code? Specifically, there are some ICD-9 codes (i.e. 347) that are only three characters and would not have a decimal point if you where to look them up in an ICD-9 codebook. There are also ICD-9 codes that are three character codes (i.e. 493) and would not have a decimal point, however, they can also be further differentiated and would then include the decimal point (i.e. 493.0, 493.00, 493.10, etc). Was the intent of V5.1 to allow pharmacies to submit the code, as it would

be found in an ICD-9 code reference book, or was the intent of V5.1 to always require a decimal point be submitted?

Response:
No. The Telecommunication Implementation Guide and Data Dictionary are incorrect. Diagnosis code fields must adhere to the owner's code set rules and formats. A Data Element Request Form (DERF) will be submitted to correct this in a future version.

MEASUREMENT UNIT (497-H3)
UNIT WITH DIMENSION

Question:
Does a document exist identifying which clinical unit (497-H3) is submitted with which clinical dimension (496-H2)?

Response:
NCPDP has not drafted a document aligning a specific Measurement Unit (497-H3) with a specific Measurement Dimension (496-H2) to allow maximum flexibility in using these fields.

VALUE CORRECTION

Question:
Should the value of 12 for Clinical Unit (497-H3) be milliliters instead of millimeters?

Response:
Field 497-H3 is the "Measurement Unit" field. You identified a typographical error and therefore are correct in stating that this should be "milliliters". We will update the Data Dictionary to correct this item.

RESPONSE SEGMENT DISCUSSION

RESPONSE HEADER SEGMENT

RESPONSE HEADER SEGMENT FIELDS NOT MODIFIED FROM TRANSACTION HEADER SEGMENT

USAGE

Question:
Should the fields submitted in the Transaction Header Segment on a request be returned without modification on the Response Header Segment? (Should they be mirrored?)

Response:
Yes. The Response Header Segment contains the field Version/Release Number, Transaction Code, Transaction Count, Service Provider ID Qualifier, Service Provider ID, and Date of Service that are also used in the Transaction Header Segment. The intent of these fields within the Response Header Segment was that the values submitted in these fields on the request from the provider to the payer would be returned **without change** in the response from the payer to the provider. These fields in the Response Header Segment are used by the software system to offer a level of verification at the transmission level that the response is paired to the request. (The Prescription/Service Reference Number in the Response Claim Segment, when applicable, may be used to match as well.)

For example, (*b* denotes a space or blank)

Transaction Header Segment

Field	Field Name	Value
1Ø1-A1	BIN NUMBER	999999
1Ø2-A2	VERSION/RELEASE NUMBER	51
1Ø3-A3	TRANSACTION CODE	B1
1Ø4-A4	PROCESSOR CONTROL NUMBER	*bbbbbbbbbb*
1Ø9-A9	TRANSACTION COUNT	Ø1
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7
2Ø1-B1	SERVICE PROVIDER ID	4563663*bbbbbbbb*
4Ø1-D1	DATE OF SERVICE	2ØØ2Ø811
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*

Response Header Segment

Field	Field Name	Value
1Ø2-A2	VERSION/RELEASE NUMBER	51
1Ø3-A3	TRANSACTION CODE	B1
1Ø9-A9	TRANSACTION COUNT	Ø1
5Ø1-F1	HEADER RESPONSE STATUS	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7
2Ø1-B1	SERVICE PROVIDER ID	4563663*bbbbbbbb*

4Ø1-D1	DATE OF SERVICE	2ØØ2Ø811

TRANSACTION RESPONSE STATUS (112-AN)
USAGE

Question:
What is the intent of the new Transaction Response Status (112-AN)?

Response:
Transaction Response Status is considered a new field in Version 5 although it is similar in nature to the "Response Status" field in older telecommunication standards. "Transaction Response Status" is defined as "Code indicating the status of the transaction." This field is used by the processor to indicate their response status to the submitted transaction.

RESPONSE MESSAGE SEGMENT
MESSAGE (5Ø4-F4) AND ADDITIONAL MESSAGE INFORMATION (526-FQ)
USAGE

Question:
Currently in Version 3.2, the Message (field 5Ø4-F4) is used in the response transaction to return information. Sometimes if more text information is needed, the Additional Message (526-FQ) field is used. In Version 5, these fields are now in two different segments. Is the usage still the same? It appears that in 5.1 the Message field no longer relates to just one script but rather to the entire transmission. Is this true?

Response:
In Version 3.2, both field 5Ø4-F4 Message and 526-FQ Additional Message Information appeared in the "script" level – meaning that they repeated for each script in a multi-scripted response. For example, in a two-scripted claim, the "Paid" response appeared as the following. Note the Message and the Additional Message fields occur in each script response.

Version 3.2

1Ø2	Version/Release Number
1Ø3	Transaction Code
5Ø1	Response Status
	Optional response header information (Plan ID)

<GS>	Group separator
5Ø1	Response Status (Prescription 1)
5Ø5	Patient Pay Amount
5Ø6	Ingredient Cost Paid
5Ø7	Contract Fee Paid
5Ø8	Sales Tax Paid
5Ø9	Total Amount Paid
5Ø3	Authorization Number
5Ø4	**Message**

	Optional response information (Accum. Ded. Amt, Amt. Applied To Periodic Ded., Incentive Fee Paid, DUR, etc…)
526	**Additional Message Information**
<GS>	Group separator
5Ø1	Response Status (Prescription 2)
5Ø5	Patient Pay Amount
5Ø6	Ingredient Cost Paid
5Ø7	Contract Fee Paid
5Ø8	Sales Tax Paid
5Ø9	Total Amount Paid
5Ø3	Authorization Number
5Ø4	**Message**
	Optional response information (Accum. Ded. Amt, Amt. Applied To Periodic Ded., Incentive Fee Paid, DUR, etc…)
526	**Additional Message Information**

In Version 5, “multi-script” was replaced with “multiple transactions in a transmission” to reflect that different transaction codes are supported not just prescriptions. The Message field appears in the Response Message Segment. The Response Message Segment occurs at the transmission level – once per transmission. ***The usage of the field Message (5Ø4-F4) should no longer be used to relay textual information with each “script”. It should be used to relay information about the entire transmission.***

The Additional Message Information field appears in the Response Status Segment. The Response Status Segment occurs per transaction, and therefore can reflect different text for each transaction in a multiple transaction transmission (“multi-scripts” in the old verbiage).

Version 5

Transmission Level

Response Header Segment		
Field	Field Name	Mandatory or Optional
1Ø2-A2	VERSION/RELEASE NUMBER	M
1Ø3-A3	TRANSACTION CODE	M
1∅9-A9	TRANSACTION COUNT	M
5Ø1-F1	HEADER RESPONSE STATUS	M
2∅2-B2	SERVICE PROVIDER ID QUALIFIER	M
2Ø1-B1	SERVICE PROVIDER ID	M
4Ø1-D1	DATE OF SERVICE	M
Response Message Segment		
111-AM	SEGMENT IDENTIFICATION	M
5Ø4-F4	**MESSAGE**	**O**

….other transmission level Segments…..

Transaction Level

Response Status Segment		
111-AM	SEGMENT IDENTIFICATION	M
112-AN	TRANSACTION RESPONSE STATUS	M
5Ø3-F3	AUTHORIZATION NUMBER	O
51Ø-FA	REJECT COUNT	O
511-FB	REJECT CODE	O***R***
546-4F	REJECT FIELD OCCURRENCE INDICATOR	O***R***
547-5F	APPROVED MESSAGE CODE COUNT	O
548-6F	APPROVED MESSAGE CODE	O***R***
526-FQ	**ADDITIONAL MESSAGE INFORMATION**	**O**
549-7F	HELP DESK PHONE NUMBER QUALIFIER	O
55∅-8F	HELP DESK PHONE NUMBER	O

It can be argued that when supporting single transactions in a transmission that use of the Message field can relay information about *the single transaction and the transmission.* However care should be taken since multiple transactions in a transmission do exist and incorrect conclusions could be taken when processing multiple transactions in a transmission if this logic is used.

RESPONSE INSURANCE SEGMENT

PAYER ID (569-J8)

USAGE

Question:
Will the Payer ID Qualifier (568-J7) and Payer ID (569-J8) be the same value for all claims received from the same processor?

Response:
The “Payer ID” is the “ID of the payer”. The “Payer ID Qualifier” is the “Code indicating the type of payer ID.” We would not make that assumption as a claims processor may run a “Service Bureau” operation in which they support the outsourcing of the pharmacy benefit manager to different payer segments and therefore different payer ID types.

PLAN ID (524-FO)

USAGE (SEE INSURANCE SEGMENT)

RESPONSE STATUS SEGMENT

APPROVED MESSAGE CODE (548-6F)

ORIGIN OF THE FIELD

Question:
What is the origin of Approved Message Code (548-6F) in the Response Status Segment?

Response:
Field 548-6F (Approved Message Code) – This is the “Approved Message Code” field. The definition of this field is “Message code, on an approved claim/service,

communicating the need for an additional follow-up." This field, along with the "Approved Message Code Count field 547-5F is intended to be used by the processor to indicate an opportunity for a subsequent follow-up action may be appropriate (e.g. a generic may be available, a preferred formulary drug, et cetera) without rejecting the claim. The subsequent follow-up action may result in a higher or additional reimbursement.

OCCURRENCE AND NUMBER OF VALUES

Question:
If the "Approved Message Code" field has a recommended occurrence of 5 times, and the number of values that can exist is three (ØØ1, ØØ2, ØØ3), how can it occur 5 times?

Response:
The definition of "Approved Message Code" is "Message code, on an approved claim/service, communicating the need for an additional follow-up." This is a new field and only three code values were created. The maximum occurrences of "5" value is a guideline (a.) anticipating the creation of additional code valued in the future and (b.) does not preclude the use of one of these values more than once in a single response.

MESSAGE (5Ø4-F4) AND ADDITIONAL MESSAGE INFORMATION (526-FQ)

USAGE

See section "Response Message Segment" for information about the use of these fields.

REJECT CODE (511-FB)

FIELD LENGTH EXPANDED

Question:
The Reject Code (511-FB) field is a character length of 3, but the data dictionary does not show the leading zeros. A leading zero on a numeric field can be truncated, but a leading zero on a character field is not (Ø7Ø = 7Ø but "Ø7Ø" is not equal to "7Ø"). Can you tell me if it will be standard practice to include the leading zero on these reject codes?

Response:
For standards prior to Version 5, the Reject Code (511-FB) field was designated as X(2). For version 5, the Reject Code field was expanded to X(3) to support more values. When the Reject Codes were brought forward, they were brought forward as originally defined. In Version 3.2, value "Ø1" (Missing/Invalid BIN) is two digits long and contains "zero one". In Version 5, value "Ø1 " is three digits long and contains "zero one space". Since it is an alphanumeric field, the trailing space may be truncated according to syntax rules.

Other fields which have expanded or changed data type should also be reviewed, according to this practice.

REJECT COUNT (51Ø-FA)

HOW MANY REJECT CODES MIGHT BE RECEIVED?

Question:
What is the maximum number for the “reject count” field? Or what is the most amount of reject codes we can expect to receive?

Response:
There is a “Repeating Fields - Maximum Occurrences” section in the Implementation Guide. For field # 51Ø-FA (Reject Count) the maximum number of occurrences is 99. The recommended number of occurrences is <= 5. The “5” is a recommendation only; trading partner requirements will dictate the desired number of occurrences displayed.

RESPONSE WITH ACCEPTED AND REJECTED INFORMATION *ALLOWED?*

Question:
Can a response transaction contain accepted and rejected information? For example, on an RX Billing (B1), could the response be returned with a Transaction Response Status of “P” (Paid) and in the Response Status Segment, Reject Code and Count fields be included to relay information? Or in another example, could a Reversal (B2) response be “A” (Approved) and Reject Code and Count fields be included?

Response:
No. The Reject Code and Count fields, which are specifically for reject situations, are to be used when the Transaction Response Status = “R” (Rejected). These fields should not be returned for values other than “R”.

This question is also addressed in the “Compound/Multi-Ingredient Processing”, “Multi-Ingredient Compounds”, “Rejecting One Ingredient” section of this document.

RESPONSE CLAIM SEGMENT

PREFERRED PRODUCT ID QUALIFIER (552-AP) *SYNTAX*

Question:
In the Response Claim Segment, the Preferred Product Count (field 551-9F) identifies how many sets of Preferred Product information are returned in the response; will the first fields of every set be Preferred Product ID Qualifier (field 552-AP)?

Response:
The “Preferred Product Count” will tell how many sets exist. This field appears once. The Preferred Product ID Qualifier (552-AP) must occur with each repetition along with the Preferred Product ID (553-AR), Preferred Product Incentive (554-AS), Preferred Product Copay Incentive (555-AT), and Preferred Product Description (556-AU). The Preferred Product ID Qualifier (552-AP) must be present for each iteration. In regards to the sequencing of fields:

- Mandatory data elements must occur first within the appropriate segment.
- Optional fields occur after the mandatory fields in a segment.
- Optional fields may occur in any order in a segment except for those designated with a qualifier on in a repeating group.

Refer to section 2.4 in Version 5 Implementation Guide.

RESPONSE PRICING SEGMENT

CAPTURED RESPONSE

Question:
Why would the Response Pricing segment be used (optional) in a Billing transaction (or other transaction) when a processor returns a “C”aptured response?

Response:

A “C”aptured response is used when the Processor/PBM accepts the receipt of the transaction but does not render a judgment regarding eligibility or payment, for example. The Processor/PBM may return copayment information. The response copay fields are found in the Response Pricing Segment.

OTHER PAYER AMOUNT RECOGNIZED (556-J5)

WHEN IS FIELD USED?

Question:
Under what conditions should processors return the Other Payer Amount Recognized (field 556-J5) in their responses? This field is necessary to calculate/validate the Total Amount Paid (field 5Ø9-F9) value returned per the Prescription Formula in sections 4.2.9 and 8.1Ø.

Response:
“Other Payer Amount Recognized” is the “Total dollar amount of any payment from another source including coupons.” The processor would return a value in this field after reviewing and accepting a Claim or Service Billing transaction with an entry in the “Other Payer Amount Paid (field 431-DV).

WILL IT CONTAIN THE SUM OF ALL OCCURRENCE AMOUNTS?

Question:
In regard to the Response field 566-J5 Other Payer Amount Recognized, will this field contain the sum of all occurrence amounts corresponding to the field 431-DV Other Payer Amount Paid? If not, the sums of what corresponding fields does field 566-J5 contain?

Response:
According to the definition, Other Payer Amount Recognized is the total dollar amount of any payment from another source including coupons. This field is used in balancing. The Other Payer Amount Field (amount of any payment known by the pharmacy from other sources (including coupons)) is not used in balancing. In looking at the definitions, Other Payer Amount Paid is totaled and included in Other Payer Amount Recognized.

RESPONSE DUR/PPS SEGMENT

DUR RESPONSE DATA

WHAT IS THE LENGTH OF THE VERSION 3.2 FIELD DUR RESPONSE DATA (525-FP)?

Question:
What is the length of the “DUR Response Data” field? The description is missing in the data dictionary.

Response:
“DUR Response Data” is NCPDP field # 525-FP and supported in telecommunications Version 3.2. In Version 3.2, the “Response Data” field was really made up of many different fields that occurred, in sequence, three times (e.g. DUR Conflict / Reason for Service Code, Clinical Significance Code, etc.) In total that group of fields were known

as the “DUR Response Data”. Therefore, since it did not have a unique identity, it was not brought forward into Version 5.Ø.

TRANSMISSION/TRANSACTION SYNTAX

ALPHANUMERIC FIELD EXPANSION

EXPANSION OF FIELD LENGTH

Question:
The Reject Code (511-FB) field is a character length of 3, but the data dictionary does not show the leading zeros. Can you tell me if it will be standard practice to include the leading zero on these reject codes? Other Payer ID Qualifier (339-6C) is defined as X(2). Is the leading zero included?

Response:
For standards prior to Version 5, the Reject Code (511-FB) field was designated as X(2). For version 5, the Reject Code field was expanded to X(3) to support more values. When the Reject Codes were brought forward, they were brought forward as originally defined. In Version 3.2, value "Ø1" (Missing/Invalid BIN) is two digits long and contains "zero one". In Version 5, value "Ø1 " is three digits long and contains "zero one space". Since it is an alphanumeric field, the trailing space may be truncated according to syntax rules.

Other Payer ID Qualifier (339-6C) both digits are used. So value "Ø1" (National Payer ID) contains "zero one". Segment Identification, which is X(2) for value "Ø7" (Claim) would contain "zero seven". This is compared to Submission Clarification Code (42Ø-DK) which is 9(2). Value 2 (Other Override) would contain "two" with the zero suppressed since it is a numeric field. Other alphanumeric fields which have expanded or are alphanumeric should also be reviewed, according to this practice.

COUNT AND COUNTER INFORMATION

USAGE

Question: Which fields are required in groupings with Count and Counter fields?

Response: Since the Telecommunication Implementation Guide Version 5.1 is "frozen" under HIPAA, please refer to future versions of the Implementation Guide (Version 5.4 and above), which have more clarification in section "2.4 Repeating Fields – Maximum Occurrences".

For technical parsing, the "count" field groupings will have a "trigger" field that must occur in each iteration or loop of the count. The trigger fields must be present when the Count is used so that the parsing routine can tell when another iteration of a count has occurred. In the excerpt from section 2.4 below, the trigger field(s) is noted in the trigger note.

For technical parsing, the "counter" field groupings use the counter field itself as the trigger. Each iteration or loop of the counter will be designated with the counter field. Within the counter grouping, all or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.

A generic example of count and counter scenarios:

Count of "3"

Count field with value 3	
Field 1a (trigger)	
	Field 1b
Field 1a (trigger)	
	Field 1b
Field 1a (trigger)	
	Field 1b

Counter of "2"

Actual Counter field with value 1 (trigger)	
	Field 1
Actual Counter field with value 2 (trigger)	
	Field 1
	Field 2

Helpful Hint: Remember that counT ends in T which stands for Total and counteR ends in R that stands for Repeats on every occurrence.

Excerpt From "2.4 Repeating Fields – Maximum Occurrences" with additional clarification

Coordination of Benefits/Other Payments Segment:

The field Coordination of Benefits/Other Payments Count (337-4C) when supported may contain a maximum count of 9 with a recommended count ≤ 3. The Count *will contain* a value between 1 and 9 when used and the fields (Other Payer Coverage Type, Other Payer ID Qualifier, et cetera) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Payer Coverage Type must be present for the Count.)

The field Other Payer Amount Paid Count (341-HB) when supported may contain a maximum count of 9 with a recommended count ≤ 9. The Count *will contain* a value between 1 and 9 when used and the fields (Other Payer Amount Paid Qualifier and Other Payer Amount Paid) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Payer Amount Paid Qualifier and Other Payer Amount Paid.)

The field Other Payer Reject Count (471-5E) when supported may contain a maximum count of 2Ø with a recommended support of ≤ 5. The Count *will contain* a value between 1 and 2Ø when used and Other Payer Reject Code will repeat the number of times the Count specifies. (Trigger: Other Payer Reject Code.)

Claim Segment:

The field Procedure Modifier Code Count (458-SE) when supported may contain a maximum count of 9 with a recommended support of ≤ 4. The Count *will contain* a value between 1 and 9 when used and Procedure Modifier Code will repeat the number of times the Count specifies. (Trigger: Procedure Modifier Code.)

DUR/PPS Segment:
The field DUR/PPS Code Counter (473-7E) when supported *may repeat* a maximum of 9 occurrences with a recommended ≤ 9 occurrences supported. The counter field indicates which sequential loop of the repetition. For each repetition of the DUR/PPS Code Counter (1, 2, 3, et cetera) the fields Reason for Service Code, Professional Service Code, Result of Service Code, et cetera will occur, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: DUR/PPS Code Counter. All or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.)

Compound Segment:
The field Compound Ingredient Component Count (447-EC) when supported may contain a maximum count of 99 with a recommended support of ≤ 25 ingredients. The Count *will contain* a value between 1 and 99 when used and the fields (Compound Product ID Qualifier, Compound Product ID, Compound Ingredient Quantity, et cetera) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Compound Product ID Qualifier, Compound Product ID, Compound Ingredient Quantity are all mandatory, as defined in the Segment Quick Reference.)

Pricing Segment:
The field Other Amount Claimed Submitted Count (478-H7) when supported may contain a maximum count of 9 with recommended support of ≤ 3. The Count *will contain* a value between 1 and 9 when used and the fields Other Amount Claimed Submitted Qualifier and Other Amount Claimed Submitted will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Amount Claim Submitted Qualifier and Other Amount Claimed Submitted.)

Clinical Segment:
The field Diagnosis Code Count (491-VE) when supported may contain a maximum count of 9 with recommended support of≤ 5. The Count *will contain* a value between 1 and 9 when used and the fields Diagnosis Code Qualifier and Diagnosis Code will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Diagnosis Code Qualifier and Diagnosis Code.)

The field Clinical Information Counter (493-XE) when supported *may repeat* a maximum of 9 occurrences with a recommended ≤ 5 occurrences supported. The counter field indicates which loop of the repetition, in sequential order. For each repetition of the Clinical Information Counter (1, 2, 3, et cetera...), the fields Measurement Date, Measurement Time, et cetera will occur, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Clinical Information Counter. All or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.)

Response Status Segment:

The field Approved Message Code Count (547-5F) when supported may contain a maximum count of 9 with recommended support of ≤ 5. The Count *will contain* a value between 1 and 9 when used and the field Approved Message Code will repeat the number of times the Count specifies. (Trigger: Approved Message Code.)

In a Rejected response, the field Reject Count (51Ø-FA) when supported may contain a maximum count of 99 with recommended support of ≤ 5. The Count *will contain* a value between 1 and 99 when used and the fields Reject Code and Reject Field Occurrence Indicator will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Reject Code.)

Either the reject or approved fields may appear, but not both, based on the response. If the field rejected is not a repeating field, the 'Reject Field Occurrence Indicator' should be eliminated.

Response Claim Segment:
NOTE: If the Preferred Product Count is sent, the Preferred Product ID Qualifier must precede each occurrence of the Preferred Product ID.

The field Preferred Product Count (551-9F) when supported may contain a maximum count of 9 with recommended support of ≤ 6. The Count *will contain* a value between 1 and 9 when used and the fields (Preferred Product ID Qualifier, Preferred Product ID, et cetera) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Preferred Product ID Qualifier and Preferred Product ID.)

Response Pricing Segment:
The field Other Amount Paid Count (563-J2) when supported may contain a maximum count of 9 with recommended support of ≤ 3. The Count *will contain* a value between 1 and 9 when used and the fields Other Amount Paid Qualifier and Other Amount Paid will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Amount Paid Qualifier and Other Amount Paid.)

Response DUR/PPS Segment:
The field DUR/PPS Response Code Counter (567-J6) when supported *may repeat* a maximum of 9 occurrences with a recommended ≤ 9 occurrences supported. The counter field indicates which loop of the repetition, in sequential order. For each repetition of the DUR/PPS Response Code Counter (1, 2, 3, et cetera...), the fields Reason for Service Code, Clinical Significance Code, et cetera will occur, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: DUR/PPS Response Code Counter. All or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.)

FIELD SIZE DIFFERENT IN HIPAA STANDARDS
USAGE

Question:

The field sizes in ASC X12N are larger than in NCPDP Telecommunication Standard Version 5.1. An example would be Subscriber ID in the 834 standard at 3Ø bytes and the NCPDP Cardholder ID at 2Ø bytes. What field length should be used?

Response:
The field length used should be the appropriate designation for that standard. The processor must be able to accept the maximum length of a field, as defined in the appropriate implementation guide. The provider may send the length appropriate for the business case.

FIELD TRUNCATION

TRUNCATION OF DOLLAR FIELDS

Question:
We coded our application to be variable and only return necessary data elements. Using the editorial document as a reference, (page 43 Zero Dollar Amounts and page 49 100% Copayment), we decided not to return Total Payment Amount on a paid response for a 100% copayment. The element is optional and would contain zeros. We return Patient Pay Amount, Copay and Amount Attributed to Production Selection. We have been following this practice since we implemented in the fall of 2002.

This week, one of our vendors migrated to 5.1. They were expecting a Total Amount Paid on 100% Copayment. This expectation was based on page 66 of the Protocol Draft #14.

The clarification concerns Page 66. Under the 100% Copay section, Total Paid Amount is not listed as a field to return unless the approved amount results in a negative amount. Based on this, we felt our response was correct for 100% Copay Paid Responses. Reading further under the Other Pricing section, there is a reference to two fields that are mandatory - Patient Pay Amount and Total Amount Paid. Are these fields really mandatory? Do you know what Version/Draft they became mandatory? I have a mix of vendors and chains on 5.1 and have not received any complaints to date. I am reluctant to change based on one Vendor but I want to be compliant.

If you could clarify the correct response for 100% copay I would appreciate it. Also, for Patient Pay Amount, is it always required even if it is zero. We have some RX's with no copay accessed. Are we to return Patient Pay Amount with zeros in those responses?

Response:
The Implementation Guide supports the truncation of fields. However, further clarification has been created. When the dollar field is supported, a value should always be returned, whether zero or higher. The only time a dollar field is not returned is when it is not supported or it's value cannot be determined. If a dollar field is sent on the request, the response-paired field should be returned so that balancing can occur. See question "***How should zero dollar amounts be handled in a variable transaction?***" See question "***100% Copay And Negative Amounts***". See also section "***Business Function of Capture***" and "***Pricing Guidelines***".

TRUNCATION OF NON-NUMERIC FIELDS

Question:
Is it proper to “truncate” non-numeric fields? For example, a 2 byte field with a value of “Ø8” is truncated to “8”. Is this proper?

Response:
A numeric field can be truncated from “Ø8” to “8”. For alpha-numeric fields you cannot truncate in this manner. A field defined as alpha-numeric of two digit length and a value of “Ø8” must be sent as “Ø8” and not “8”

TRUNCATION OF NUMERIC FIELDS

Question:
In the Telecommunication Standard, a field such as Patient Location (3Ø7-C7) is defined as a two-byte numeric with values 1-11. Can I send the leading zeroes in values 1-9 (meaning sending Ø1, Ø2, Ø3..., or 1, 2, 3)?

Response:
Yes. For optional numeric fields used in the Telecommunication Standard, sending the leading zero(es) is permissible, or truncating the leading zero(es) is permissible. For an optional numeric field, a value of Ø1 is the same as 1 and either are permitted. As a further note, when numeric fields are in a mandatory fixed length segment, such as the Transaction Header Segment or Response Header Segment, the numeric fields must be padded with zeroes to the maximum length of the numeric field.

The following verbiage will be added to the Telecommunication Standard and Implementation Guide.
Numeric Truncation:
For optional numeric fields used in the Telecommunication Standard, sending the leading zero(es) is permissible (but not recommended), or truncating the leading zero(es) is permissible (and recommended). For an optional numeric field, a value of Ø1 is the same as 1 and either is permitted. A value of ØØ15 is the same as 15 and either is permitted.

When numeric fields are in a mandatory fixed length segment, such as the Transaction Header Segment or Response Header Segment, the numeric fields must be padded with zeroes to the maximum length of the numeric field.

Alphanumeric Truncation:
For optional alphanumeric fields used in the Telecommunication Standard, sending the trailing space(s) is permissible (but not recommended), or truncating the trailing space(s) is permissible (and recommended). For an optional alphanumeric field, a value of "1 " is the same as "1" and either is permitted. A value of "ØØ1 " is the same as "ØØ1" and either is permitted.

When alphanumeric fields are in a mandatory fixed length segment, such as the Transaction Header Segment or Response Header Segment, the alphanumeric fields must be padded with spaces to the maximum length of the alphanumeric field.

TRUNCATION OF FIELDS IN THE SEGMENT

Question:

If you choose to truncate any fields, does this apply to the entire transaction?

Response:
You should be prepared to support any combination of "Truncated" and "Non-Truncated" field combinations. There is no rule requiring that all fields should be truncated within a transaction. Some fields may be truncated and some may not.

MANDATORY FIELDS FIRST IN SEGMENTS

NCPDP MANDATORY FIELDS VERSUS A PROCESSOR'S BUSINESS NEED OF MANDATORY FIELDS

Question:
If mandatory fields are sent first in the segment, does this mean only NCPDP standard identified mandatory fields? For instance, if a field is defined as optional in the standard, but a processor has defined it as mandatory for their implementation, is the field sent with the standard mandatory elements or still submitted with the stand defined optional elements?

Response:
The mandatory fields requirement is for the NCPDP defined fields. If that segment is used, the mandatory fields must be used and must come first. A processor may choose to make some of the optional fields mandatory for their business need, but that would not change the order of the mandatory fields.

Question:
Other than sending mandatory fields first followed by optional fields, is there a defined order of submission of fields (i.e. follow the order of the fields in section 5 of the Implementation Guide)? Can a processor define the order of fields?

Response:
By definition, the optional fields may occur in any order except where a field and it's qualifier must occur together, or in a repeating group (where counts/counters are used). There is no defined order to the optional fields, but practice may show that many will use the order defined in the implementation guide. A processor cannot define the order of the fields as this is the Standard and Implementation Guide's responsibility, and the order is already defined by the above rules. However, the processor may send out a payer sheet that would list the fields, hence giving it a particular order. Section 8.1 Overview of the Specification should be used as a reference.

MANDATORY QUALIFIERS AND FIELDS – USAGE OF DEFAULT VALUES

USAGE OF DEFAULT (LOW-VALUES) ON MANDATORY QUALIFIERS AND FIELDS

Question:
When a qualifier or field qualified is mandatory in a segment, how are default values of zeroes and spaces handled?

Response:
Every field, by its existence, has a default or low value. Numeric fields default to zeroes, alphanumeric default to spaces. In the Data Dictionary, for fields that are code lists, a value of ØØ or 99 or blanks has been created to clarify what the value of "Not Specified"

would be. The data fields may be used by other standards that may need a default or low value for the field.

When a field or a qualifier is defined as mandatory in the Telecommunications Standard and Implementation Guide, low values are not acceptable values. If this were allowed, the field filled with zeroes or spaces would function as a placeholder. The field would not function as a needed element. This is not the intention.

If a mandatory qualifier were filled with low values, what would "Not Specified" mean? If a valid qualifier were used and paired with a space-filled field qualified, what would that denote? When a field or a qualifier is mandatory, valid values should be used (non-low values).

If there is an exception to this rule, it is noted for a specific business case in the Implementation Guide. For example, when submitting a Billing for Service of DUR/PPS, the Product/Service ID Qualifier (436-E1) contains a value of "Ø6" (DUR/PPS). The Product/Service ID (4Ø7-D7) contains a value of "Ø" since there is not a specific product or service number associated with the qualifier at this time.

MAXIMUM LENGTH

WHAT IS THE MAXIMUM RECORD LENGTH IN VERSION 5?

Question:
What is the maximum record length we can expect for a 5.Ø record? The old maximum length we used was 1712.

Response:
For the purpose of discussion, we will look at the claim submission record. A single Version 5.Ø claim record, with all optional fields and without any truncation or repeating fields, is over 1,7ØØ characters long. Multiply this number by the maximum 4 claims per transaction and the length is well over 6,8ØØ characters. With truncation the claim could be less than 3ØØ characters long. Version 5.Ø is intended to be "truly variable" and suggest that all participants develop their implementation plans accordingly.

PRINTABLE CHARACTERS

USAGE

Question:
What are printable characters?

Response:
All characters in the ASCII chart from 32 - 126 (2Ø – 7E hex), which include:

<space>
Ø123456789
ABCDEFGHIJKLMNOPQRSTUVWXYZ
~`!@#$%^&*()_-=+\|{[]}:,<.>/?;'"
abcdefghijklmnopqrstuvwxyz

See Note below.

The ASCII character codes from Ø - 31 (Ø - 1F hex) are considered to be control characters and are not allowed as data characters in a claim. Likewise, characters higher than ASCII 126 (higher than 7E hex) should not be used because of the 7 data bit Even parity requirement for VISA dial-up transmissions.

The use of characters such as commas, tabs and quotes can interfere with routines used to parse claims data and should be avoided if possible.

Note:
In the Telecommunication Standard, the following is defined:

> ""A/N" = Alpha/Numeric, upper case when alpha, always left justified, space filled, upper case, printable characters.
>
> Truncation: "1234ABC44bbbbb" becomes "1234ABC44"".

The Implementation Guide further states

> "Alpha/Numeric, always left justified, space filled. A-Z, Ø-9, and printable characters."

In Telecommunication Standard allows the use of

> <space>
> Ø123456789
> ABCDEFGHIJKLMNOPQRSTUVWXYZ
> ~`!@#$%^&*()_-=+\|{[]}:,<.>/?;'"

The use of lower case letters ASCII 97 - 122 (61 - 7A hex) is not allowed in the Telecommunication Standard.

Question:
Can characters, i.e.: alpha, numeric and symbols (if allowable) be separated by spaces?

Response:
Yes. Example of embedded and trailing blanks with the truncation rule in effect:

> "ABCbDb-bEbbbb" becomes "ABC D - E"

The same example without truncation in effect:

> "ABCbDb-bEbbbb" remains as "ABC D - E "

REJECTING TRANSACTIONS

HOW IS A REJECTION HANDLED WHEN THE PROBLEM IS IN THE HEADER?

Question:
A transaction with multiple claims is rejected by the processor at the header. Do you have to reject each claim in the response?

Response:
In Version 5.Ø “header only” reject transactions don’t exist. This was confusing in Version 3.2. In Version 5.Ø, it is recommended that the rejection be at the Response Header and Transaction Response level. However, this is not mandatory.

Please refer to section ***"Transmission Response Discussion"*** of the Telecommunication Standard.

INVALID VERSION/RELEASE NUMBER (1Ø2-A2), TRANSACTION CODE (1Ø3-A3), OR TRANSACTION COUNT (1Ø9-A9)

Question:
How should a clearinghouse or payer handle rejecting a transaction sent from a provider with an invalid Version/Release Number (1Ø2-A2), Transaction Code (1Ø3-A3), or Transaction Count (1Ø9-A9)?

Response:
The recommendation is that when the Transaction Count (1Ø9-A9) is invalid, the processor system should generate a Transmission Rejected/Transaction Rejected format. The processor system should generate a response with a Transaction Count (1Ø9-A9) of 1 and appropriate Reject Codes (511-FB).

It is possible that the processor system may not respond to this invalid transaction, or may respond with only a string or text message, not in NCPDP format. This would then appear as a timeout to the provider system.

If the Version/Release Number (1Ø2-A2) is garbage (not a valid value, or values for example of "??" or "**"), the processor cannot build an appropriate response. In this case, a timeout at the provider system is appropriate.

If the Transaction Code (1Ø3-A3) is garbage (not a valid value, or values for example of "??" or "**"), the processor system does not know how to build an appropriately formatted response.

If the Transaction Count (1Ø9-A9) is not a valid value (but the Version/Release and Transaction Code are appropriate), it is recommended the Transaction Count contain a value of 1 with the appropriate Response Status Segment containing Reject Codes (51Ø-FA) signifying the invalid Transaction Count field.

ZERO DOLLAR AMOUNTS

SUPPORT OF ZERO DOLLAR AMOUNTS

Question:
How Should Zero Dollar Amounts Be Handled In A Variable Transaction?

Response:
The NCPDP Telecommunication Standard Version 5 provides the ability to only send/receive the data necessary to fulfill a business requirement.
In the past, the version 3.2 formats allowed the fixed transaction formats of 3A, 3B, and 3C. Due to the fixed formats, fields that were not needed in the business case still had to be defaulted (zero or space filled) to retain the position in the fixed format.

Version 5 does not bring the fixed formats forward. By adhering to the rules of which segments are required, which fields are mandatory, and only sending/receiving the fields

that are optionally needed for the business case, fields that are not needed, should not be sent.

Dollar amounts should not be sent unless needed in the business case. If it is necessary to relay a dollar field that contains zeroes, the field should be sent. It is **not recommended** to relay a dollar field of zeroes to retain a position in a segment. Please see the appropriate segment sections within the Version 5.1 or greater Implementation Guide for clarification.

TRANSLATION OF VERSIONS

FIXED FORMAT VERSUS VARIABLE FORMAT

WHY IS IT IMPORTANT TO MOVE FROM FIXED FORMAT TO A VARIABLE FORMAT?

Question:
Why is it important to move from a fixed format to a variable format with NCPDP Version 5.1?

Response:
Based on member requests for new fields, expanded fields, and new business cases, it was necessary to add new data elements to the data dictionary. With the expansion of data elements, using a fixed format would have created a transaction set that was larger and would need to be supported in each transmission. To take advantage of efficiencies in transmission and to only send the data elements necessary to the business case, a variable format was created.

The Transaction Header Segment retained important routing fields in the same positions (BIN, Processor Control Number, et cetera) so multiple versions could be supported technically.

VERSION TRANSLATION

FEASIBILITY OF VERSION 3C TO VERSION 5 UPWARD/DOWNWARD COMPATIBILITY

Question:
Can you discuss the feasibility/practicality of Version 3C to Version 5 upward/downward compatibility?

Response:
The upward/downward translation may be possible with analysis. However, the changing sizes, formats, and values must be taken into account, and these changes could make translations difficult or problematic. Also the mapping of different sized dollar fields must be reviewed carefully.

Translation of Version 32 into an RTDS (3A, 3B, 3C) or Version Ø1, a downward translation, was possible because most of the translation involved the repackaging of the data fields into a slightly different format. A Version Ø1 response could be remapped back into a Version 32, 3A, 3B, or 3C response, in many cases. Even a Version Ø1 request translated upward to a Version 32, 3A, 3B, or 3C was possible in some cases, since most of the same data elements, sizes, and values were supported. The data dictionary did not change significantly.

In Version 5, the data dictionary underwent many changes. Analysis would need to account for fields, field sizes, and values that are sent in a Version 5 request and how these would translate downward into a Version 32. Longer field lengths might be truncated. Values that are not supported would either be translated or could not be sent as the Version 32 structure might not support it.

Analysis should include how to support Version 5 response fields that are not supported in lower versions. If the processor/PBM returns a response in Version 5, but the

pharmacy sent a Version 32, how are fields that do not exist in Version 32 handled? What are the translation rules for response fields in Version 5 that do not exist in Version 32? Dropping these fields might be an issue. What about field sizes or values not supported in Version 32; how are these translated?

So it may be possible to translate upward/downward. Careful analysis and clearly defined business rules between partners must be done to evaluate need.

BUSINESS FUNCTION OF CAPTURE

VALID USES

In Claim/Service Billing, a "C" (Capture) response is supported. NCPDP members have defined the business of capture to be used for:

1. **Intermediary Services** - two valid Intermediary services are:
    a. Provider/Intermediary agreements to provide services such as additional editing, pricing, billing, and payment reconciliation.
    b. Payer/Intermediary agreements to provide some level of editing, pricing, and copay calculation, with the ultimate payer having the option to perform additional edits.
2. **Replacement of manual billing**

The usage of this type of Capture should be used with caution, due to issues of:

- The determination of patient copay
- Most plans today expect patient to pay some portion.
- Many plans vary copay based on brand/generic.
- Drug Databases do not categorize drugs the same way.
- Some drugs/patients are excluded from copays.

To determine copay, providers can attempt to edit and determine copay and submit this on the original claim in the field Patient Paid Amount Submitted (433-DX), *however,*

- The resulting copay may be incorrect.
- This could be considered fraudulent if patient is overcharged.
- There is a problem with the recommendation to echo back the submitted fields.

Therefore, to support replacement of manual billing, the processor should

- Determine the copay and return it as Patient Pay Amount (5Ø5-F5).
- Then calculate Total Amount Paid (5Ø9-F9) using the submitted fields and the determined copay amount.

For example:

Ingredient Cost Submitted (4Ø9-D9)	35.ØØ		Ingredient Cost Paid (5Ø6-F6)	35.ØØ
Dispensing Fee Submitted (412-DC)	3.ØØ		Dispensing Fee Paid (5Ø7-F7)	3.ØØ
Incentive Amount Submitted (438-E3)	1.ØØ		Incentive Amount Paid (521-FL)	1.ØØ
Flat Sales Tax Amount Submitted (481-HA)	.25		Flat Sales Tax Amount Paid (558-AW)	.25
Percentage Sales Tax Amount Submitted (482-GE)	.75		Percentage Sales Tax Amount Paid (559-AX)	.75
Other Amount Claimed Submitted (48Ø-H9)	1.ØØ		Other Amount Paid (565-J4)	1.ØØ
			Patient Pay Amount (5Ø5-F5)	1Ø.ØØ
Gross Amount Due (43Ø-DU)	41.ØØ		Total Amount Paid (5Ø9-F9)	31.ØØ

Patient Pay Amount (5Ø5-F5) is 'real' and Total Amount Paid (5Ø9-F9) is calculated using submitted fields and 'real' copay.

CAPTURE CONSISTENCY

The use of a "C" (Capture) response should be *consistent* within a **BIN Number** (1Ø1-A1)**/Processor Control Number** (1Ø2-A2) combination. All claims at all times for this **BIN/PCN** combination should be handled the same way. If the processor "P" (Paid) or "R" (Rejected) this claim were it submitted at a different time, a Capture Response should **not** be used. With this consistency, providers should be able to know by trading partner agreement when returned dollar amounts are parroted versus when they are estimated dollar amounts.

Suggested Rule of Thumb:

Submitted dollar amounts = Response Captured dollar amounts
assume parroted values from submission returned
Submitted dollar amounts not = Response Captured dollar amounts
assume estimated values returned

BUSINESS FUNCTIONS NOT SUPPORTED FOR CAPTURE

The following business functions for Capture are not supported:

- 1ØØ% Copay – This is technically a payment and a "P" (Paid) response should be returned.
- Maintenance Windows – this is a Reject. Suggest use of Reject Code (511-FB) = 96 – *Scheduled Downtime*; however any 9x error code would supply provider with information to reprocess claim later.
- Coordinated Pro-DUR – this business function should take place within a "P" (Paid) or "R"(Rejected) response.
- Product Ordering – this is not a function of a Claim or Service Billing.

PRICING GUIDELINES

1ØØ% COPAY

When the patient is expected to pay 1ØØ% of processor determined amount as total claim reimbursement, it is recommended the response contain:
Patient Pay Amount (5Ø5-F5) *plus* any of the *applicable* Patient Responsibility fields included in this amount:

- Amount Attributed To Sales Tax (523-FN)
- Amount Applied To Periodic Deductible (517-FH)
- Amount Of Copay/Co-Insurance (518-FI)
- Amount Attributed To Product Selection (519-FJ)
- Amount Exceeding Periodic Benefit Maximum **(**52Ø-FK)

If processor calculates 1ØØ% copay that results in the customer paying more than pharmacy will net for the claim, Total Amount Paid (5Ø9-F9) must be provided *with a negative value* so the sale can be booked correctly.

1ØØ% COPAY AND NEGATIVE AMOUNTS

Question:
Under what situation would a Total Amount Paid (5Ø9-F9) be sent to the pharmacy with a negative dollar amount?

Response:
In some discount card or unfunded business programs, the patient pays an additional fee that is then deducted from the pharmacy's remittance (the amount the pharmacy is overpaid by the member). The patient pay amount is the normal ingredient cost plus dispensing fee, which represents the normal contracted rate for the pharmacy. In addition, the additional processing fee will be added to the patient pay amount such that the patient pay amount exceeds the payable amount to the pharmacy.

In following the total amount paid calculation, the end result will be a negative total amount paid to the pharmacy. The pharmacy will collect the total amount from the patient and book a negative amount in the pharmacy system. The payer/processor will then deduct the negative amount within the remittance process.

An example is as follows:

5Ø6-F6	Ingredient Cost Paid	19.5Ø
5Ø7-F7	Dispensing Fee Paid	2.5Ø
521-FL	Incentive Fee Paid	-------
565-J4	Other Amount Paid	-------

	Net Provider Reimbursement	22.ØØ

5Ø5-F5	Patient Pay Amount	24.ØØ
5Ø9-F9	Total Amount Paid	- 2.ØØ

Pharmacies requested a negative fee be returned on the response in order for revenue to be booked correctly at point of sale rather than creating a problem when the

pharmacy payment is received with negative dollars. (The X12 835 Remittance Advice standard can handle the negative amounts within that process.)

OTHER PRICING

- The fields containing the values used to arrive at the final reimbursement must be detailed on the response record.
- If claim submission included the field with a value not equal to zero, then the *corresponding* response field should be returned - even if the response value for that field = zeros.

The following fields should be mandatory on all payment and capture responses:

- Patient Pay Amount (5Ø5-F5)
- Total Amount Paid (5Ø9-F9)

It is the sum of these two fields that determines final provider reimbursement. With both fields present (even when zero) there is no ambiguity regarding the final payment amount of the claim.

If the Transaction Response Status (112-AN) = C (Captured) or Q (Duplicate of Captured), dollar fields should be supplied in the response.

- If the response is a 'true' Capture (i.e. replacement of batch billing, with no edits or pricing), then corresponding response fields should be populated with values as submitted. *Ideally, processor should provide 'real' copay values on a Capture. If this is not possible, provider must **know** (by trading partner agreement) the copays to charge and factor that into their system so collection occurs.*
- If the response is captured by an Intermediary who can provide better pricing criteria, the corresponding response fields should be populated with the *probable* values and those values used to determine estimated pricing as noted above. Since the claim has **not** been fully adjudicated, this should remain a capture response.
- When processor is doing maintenance, claims should be rejected. The recommendation is to use Reject Code (511-FB) = **96** - ***Scheduled Downtime*** however; other 9x codes could be used if the maintenance was not scheduled. The reject code lets the provider know to reprocess the claim at a later time.

PATIENT PAID AMOUNT SUBMITTED (433-DX)

INTENDED OR ACTUAL?

Question:

What is the official use of the Patient Paid Amount Submitted (433-DX) field? Is it supposed to be the copay from a primary/secondary payer on a secondary/tertiary claim? Or is it meant to represent cash already paid the pharmacy up front? Or something else entirely?

A processor of 3rd party claims, has been trying to use it in both 3.2 and 5.1 claims, wanting the dollar amount to represent the copay returned by the primary (or secondary) payer during a COB transaction. For example, if the claim went to the primary, with 100.00 AWP, 2.00 Fee, and 150 U&C, and the claim accepted response came back with

an accepted cost of 100.00, with the 2.00 fee, and a 25.00 copay, the processor wants that 25.00 in the Patient Paid Amount Submitted (433-DX) field of the secondary claim to them. Is this correct?

Response:

Patient Paid Amount Submitted (433-DX) is defined in the NCPDP Data Dictionary as, "Amount the pharmacy received from the patient for the prescription dispensed."

After many discussions about the use of this field, WG1 Telecommunication determined that this field should be used, as it is defined, not for intended payment monies. During the August 2003 Work Group meetings, the WG1 attendees approved a solution that was approved in Medicare situations (section "NCPDP Batch Standard – Medicare-Related Questions, subsection "Medicare Crossover Claims".) It was felt that "one" solution should be used, even though there may be variation based on the fields that each payer needs in their program. It is recognized that the most appropriate solution, exists in Telecommunication Standard Version 5.5.

The Other Payer Amount Paid Qualifier (342-HC) with loops as appropriate should be used. For the reiteration of value '99', the order should always be Deductible Amount followed by Coinsurance Amount and Copayment Amount. Also, that, of these three Amounts, nothing below the last Amount that is needed to be populated should be sent but everything above the last Amount that is needed to be populated should be sent. In other words, if there is a Deductible Amount and Copayment Amount to be sent, Coinsurance Amount will occur after Deductible Amount but with zero $ amounts. Likewise, if there is a Deductible Amount to be sent but no Coinsurance or Copayment Amounts, the "99" values should not be repeated for Coinsurance and Copayment Amounts.

Use the Other Payer Amount Paid Qualifier (342-HC) field with the values to indicate the information needed:

Medicare Allowed Amount = 'Ø7'
Medicare Paid Amount = 'Ø8'
Deductible Amount = '99'
Coinsurance Amount= '99'
Copayment Amount = '99'

Based on discussions, the above scenario was discussed and it was agreed that this scenario would be used.

PAYMENT AMOUNT BASED ON DISPENSED OR INTENDED?

Question:
Do NCPDP standards require the payment amount to be based on the amount actually dispensed, or can the intended amount be used instead?

Response:
No, the standards do not require the payer to pay either way. The determination of the whether the payer will pay based on quantity dispensed or quantity intended to be dispensed is a trading partner decision.

TRANSACTION FEE CHARGE

Question:
A processor charges a claim transaction fee per claim (is not applied to reversals). In a 100% copay or zero balance due claim scenario, the pharmacy would actually be in a negative balance after member copay is paid since they must pay the transaction fee (click fee) to the processor. The member in this instance is **not** responsible for the transaction fee and it would not be included in their copay. How could this be shown on a prescription response using the formula?

Response:
There is not a field in the Telecommunication Standard to handle this need at this time. The 835 Remittance Advice provides the ability to account for this fee. If the field is needed on a claim-by-claim basis using the NCPDP formats, the requester should submit a Data Element Request Form (DERF) for this business need.

COMPOUND/MULTI-INGREDIENT PROCESSING

COMPOUND IDENTIFIERS

HOW DO I ENTER AN INGREDIENT IN A COMPOUND THAT DOES NOT HAVE AN IDENTIFIER (FOR EXAMPLE WATER)?

Question:
Identifying each ingredient in a compound is important in order for the ingredients to support the sum total of the quantity.

Response:
The Compound Product ID Qualifier has many values (i.e., NDC, UPC) that should be used when possible. If not, trading partners need to agree on usage. When an ingredient does not have an identifier, it is possible to use the value of ØØ (not specified) in the qualifier and an agreed upon value for the product.

COMPOUND INGREDIENT CALCULATES TO BE LESS THAN $Ø.ØØ5

Question:
The basic question being raised in this example is if an ingredient in a compound calculates to be less than $Ø.ØØ5 cent for the dosage being prescribed, should optional field Compound Ingredient Drug Cost (449-EE) and Compound Ingredient Basis of Cost Determination (49Ø-UE) be sent for this drug in the compound segment.

For this example the compound will contain 4 ingredients:

NDC	Name	Strength	Pack Sz	Cost	Qty in Cmpd	Ext. Cost
00574-0421-25	Hydrocortisone Acetate		25	$56.20	1.500	$3.372
00395-1619-64	Menthol Crystals		120	$17.56	.060	$0.0087
00395-0467-92	Camphor Spirits Sol.		60	$0.97	.060	$0.00097
60432-0546-16	Lindane Lotion	1%	480	$47.06	60.00	$5.882

As you can see from the index above, the Camphor Spirits has an extended cost of less than $Ø.ØØ5 (actually less than $Ø.ØØ1). Should optional field 449-EE and 49Ø-UE be sent with this drug because 1) without these fields the compound segment is not recognizable by the processor or 2) the fields should be sent with zeroes in them or should they be omitted all together because 1) the fields would be zero and the Implementation Guide recommends that you truncate leading zeroes and trailing blanks or 2) the Implementation Guide states that these fields are “Optional” and not mandatory for the providers to send in any situation.

Response:
These fields should be sent, even if the Compound Ingredient Drug Cost (449-EE) rounds to zero.

DUR FOR COMPOUNDS

PROCESSING

Question:
On compounded claims, does DUR "hit" each drug within the compound?

Response:
Yes, the standard does allow it.

MULTI-INGREDIENT COMPOUNDS
REJECTING ONE INGREDIENT

Question:
A processor supports multi-ingredient compounds and receives a Billing transmission for a multi-ingredient compound with three (3) ingredients. One (1) ingredient is not covered. Does the processor reject the transmission? Or can the processor send back a “P” (Paid) response and in text note the ingredient not covered?

Response:
The processor must reject the Billing transmission for the multi-ingredient compound if one or more ingredients are not covered or do not meet business requirements. The processor cannot send back a “P” (Paid) response and in text note the ingredient not covered.

Although structurally the standard might support this scenario, the analysis has not been done to determine the impact on the structure and the fields in the response, for example, the amount fields.

Resubmission of the Billing with the value 8 (Process Compound for Approved Ingredients) in Submission Clarification Code (Field 42Ø-DK) will indicate the pharmacist’s acceptance of payment for covered ingredients only.

The processor may support the initial submission of the Billing with the value 8 (Process Compound for Approved Ingredients) in the Submission Clarification Code (Field 42Ø-DK). If the claim meets business criteria, the processor will pay the two (2) ingredients and by process of elimination the pharmacy knows that the third ingredient is not payable. (This might be done in situations where the pharmacy knows the criteria of a benefit plan and knows ahead of time that an ingredient might be rejected.)

If the pharmacy is not sure whether all ingredients will pay and wants to know why one or more would reject, the Submission Clarification Code (Field 42Ø-DK) should not be submitted on the original Billing.

(Similarly, the processor cannot reject the Billing because of one ingredient but send information on the payment of the other two ingredients. Structurally, a Reject response does not support the Response Pricing Segment.)

ORDER OF COMPOUND INGREDIENTS
SUBMITTED IN HIGHEST QUANTITY ORDER?

Question:
Should compound ingredients be put in highest usage amount order? (i.e., product A 8Ø%, product B 1Ø%, product C 1Ø%).

Response:
The order of the compound ingredients should not make any difference when submitting a claim.

PARTIAL FILL COMPOUNDS

BILLING FOR A PARTIAL FILL COMPOUND

Question:
How do I bill for a partial fill of a compound?

Response:
The partial fill of a compound may be handled the same as a partial fill of any other prescription.

PRODUCT/SERVICE ID (4Ø7-D7) AND PRODUCT/SERVICE ID QUALIFIER (436-E1) IN CLAIM SEGMENT

Question:
Should the Product/Service ID Qualifier be Ø3/NDC or is blank or ØØ/Unspecified acceptable?

When the claim is using the Compound Segment for a multi-ingredient compound and a value of all zeroes is submitted in the Product/ Service ID on the Claim Segment, what is the value of the Product/Service ID Qualifier?

Response:
The Telecommunication Standard Implementation Guide defines in section "***Compound Segment***":

> "When billing for multiple ingredients, use the following Claim and Pricing Segment fields:
> Product/Service ID (Field 4Ø7-D7) – defaults to zero (Zero means "Ø".)"

Further clarification in this section cites:

> "Product/Service ID Qualifier (Field 436-E1) – defaults to "ØØ""

The Product/Service ID must contain a value of "Ø" and Product/Service ID Qualifier must contain a value of "ØØ" when used for multi-ingredient compounds.

QUANTITY DISPENSED (442-E7)

MULTI-INGREDIENT COMPOUNDS

Question:
When we submit a multi-ingredient compound, what should we put in field Quantity Dispensed (442-E7)? In the Version 7.Ø Imp Guide (and the Version 5 Editorial document) there are directions for what to do with this field when submitting the most expensive ingredient (compound scenario).

Looking at the Examples of billing with the Compound Segment, Quantity Dispensed is not the sum of the individual ingredients and when you look at the detail -- due to some

ingredients being tablets and others MLs I don't know how one would be able to summarize this. But that still doesn't tell me what I should put in 442-E7.

Response:
The quantity of the final compounded product goes in this field. If you mix 1ØØ ML of one drug, with 12 tablets of another drug (you crush and mix) with yet another 5Ø ML of another drug and you put all this into 3Ø capsules---the quantity for 442-E7 would be 3Ø. What is put into the bottle that leaves with the patient is 3Ø capsules or 3Ø eaches when reporting.

The use of Quantity Dispensed (442-E7) is the quantity of the final compounded product.

QUANTITY DISPENSED (442-E7) AND COMPOUNDS

Question:
I'm wondering if any of you have run into this as an issue. I found this statement (below) in the Version 5 Questions document, which is causing some issues for us. I have a pharmacy whose software is hard-coded to sum the quantities for all ingredients of a compound and populate Quantity Dispensed (442-E7) with this value whenever they submit a compound using the claim segment (not the new compound segment). It causes denials for some drugs where we have quantity restrictions in place. We have instructed the pharmacy to submit only the quantity for the submitted NDC, not for all of the ingredients in the compound.

We have received pushback, with them saying "this in not consistent with the NCPDP standards", which is hard to argue with, given the statement below. Or is this just a suggestion of how one might submit a compound without using the compound segment, and that it should be decided by the involved business partners?

Do any of you remember the rationale of why the existing (3.x) quantity supply logic for compounds would change going to 5.1? I would think field Quantity Dispensed (442-E7) would only have the quantity submitted sum of all ingredients (or, total ML of solution dispensed, etc) only if the pharmacy submits the new compound segment and the processor accepts the new compound segment, which would break down the quantity submitted by ingredient.

From the guide:

> ALTERNATE OPTION - OPTION 2 - USING THE CLAIM SEGMENT
> A Compound may also be submitted using the Claim Segment without submitting the Compound segment. Option 1 above is the recommended option. This can be accomplished by using one of the following scenarios:
> Scenario A (Most expensive legend drug):
>
> Submit a compound entering a 2 in the Compound Code (field 4Ø6-D6).
> Submit the Product/Service ID (NDC for example) of the most expensive legend drug (field 4Ø7-D7).
> Enter the sum of all the individual quantities as Quantity Dispensed (field 442-E7).
> Enter the sum of all ingredient costs in the Ingredient Cost Submitted (field 4Ø9-D9).
>
> Scenario B (Billing codes):

Using the values listed below in the Claim Segment, Product/Service ID (Field 4Ø7-D7) for submission, by trading partner agreement, of the most expensive ingredient for compound ingredient claims.

Response:
The documented way in the Alternate Option section is to use the sum of all the individual quantities. The use of the Compound Segment will resolve the issue. Historically, the pharmacy has submitted the Quantity Dispensed (field 442-E7) of the finished product. The work group believes the wording should be clarified in a future version.

REJECTING FOR NOT SUPPORTED COMPOUND OPTIONS
THREE METHODS; ONE METHOD SUPPORTED

Question:
What if you do not support Compounds in 5.1? How do you reject this?
Or, what if you support one recommended way and not the others. How do you reject this?

Answer:
At this time, there is not a reject code for "compounds not supported" or a reject code for each of the three methods not supported. Please see “Appendix D. Billing For Compounds” in this document for discussion of the three methods.

It is recommended that

1. If you do not support multi-ingredient compounds (the Recommended Method), the Reject Code (511-FB) to use is "M/I Compound Segment" (PF).
2. If you do not support the Alternate 2 Scenario 1 using the Claim Segment - most expensive legend - the Reject Code (511-FB) to use is M/I Compound Code (2Ø).
3. If you do not support the Alternate 2 Scenario 2 using the Claim Segment - Billing codes/legend drug - the Reject Code (511-FB) to use is M/I Product/Service ID (21).

The Message field (5Ø4-F4) and the Additional Message Information (526-FQ) fields can be used to provide additional explanation.

REVERSAL TRANSACTION
USE OF PRODUCT/SERVICE ID (4Ø7-D7) AND COMPOUND CODE (4Ø6-D6)

Question:
On a compound billing the Product/Service ID field (4Ø7-D7) on the Claim Segment will have a default value of zero and the NDCs for the compound ingredients will come in on the Compound Segment in the Compound Product ID field (489-TE). On a Reversal transmission, since the Compound Segment is not transmitted, what should I expect to see in the Product/Service ID field - zero or one of the compound ingredients? Also, should the Compound Code field (4Ø6-D6) be utilized in reversal processing?

Response:

The Telecommunication Implementation Guide states that the Product/Service ID “defaults to zero” on the original claim when billing a compound with multiple ingredients. Therefore, on a Reversal, the Product/Service ID must contain the same value as in the original billing. A zero “Ø” would be submitted in the Product/Service ID (4Ø7-D7) field on a Reversal.

Note that since the Product/Service ID is an alphanumeric X(19) field in Version 5, the values of "Ø", "ØØ", "ØØØ", etc are very different values. For the above situation, the value of “Ø” is submitted on the original Claim/Service Billing and on the Reversal. (In Version 3.2 the NDC Number (4Ø7-D7) was a numeric 9(11) field in which case zero (Ø) or zeroes (ØØ) (ØØØØØØ) would all mean the same thing.

The Compound Code (4Ø6-D6) field should not be submitted in the reversal process since the reversal is tying back to the original claim. The Protocol Document, when completed, will note this field as “Not Used”.

TRANSACTION DISCUSSION

ELIGIBILITY TRANSACTION

GROUP SEPARATOR

Question:
The Telecommunication Standard Implementation Guide 5.1 on page 2 it states that "A transmission consists of one or more transactions separated by group separators. With one exception, the Eligibility Verification transmission, which does not use a group separator...." This is also mentioned in the Telecommunication Standard Specification Version 5 Release 1 on page 34.

However, in the Telecommunication Standard Specifications Version 5 Release 1, on page 88 under the Eligibility Verification Response diagram, it shows a group separator in the message.

There appears to be a conflict here. Which one is correct? Does the statement in the Implementation guide apply only to the Eligibility Verification Request or to both the Request and Response?

Response:
The transmission of the Eligibility request does not have a Group Separator. The transmission of the Eligibility response does have a Group Separator, so that all response transmissions can be parsed the same way (with the Response Status Segment coming after the Group Separator). The members discussed putting the Group Separator in the Eligibility request, but determined it was extraneous since the only "transaction level" segment was the Pharmacy Provider Segment and as optional, may not be sent. The Group Separator was therefore not supported in the Eligibility Verification request.

PRIOR AUTHORIZATION TRANSACTION

NOTABLE CLARIFICATIONS

PRIOR AUTHORIZATION CLARIFICATIONS

Please see "Appendix C. Prior Authorization Clarifications" for important information on the use of the Prior Authorization transactions.

PRIOR AUTHORIZATION REQUEST ONLY TRANSACTION

RESPONSE STATUSES

Question:
If the Prior Authorization Request Only Transaction is sent and the Prior Authorization is not assigned at that time, then does the Transaction come back with a "C" Captured or an "F" Prior Authorization Deferred? What is the difference between a "C" and "F"?

Response:
"C" is used by the processor to acknowledge receipt of a request but is not making any judgment about the request at this time. "F" is used by the processor to notify the

originator of a deferment of a prior authorization request. You can find additional information about deferment in the Version 5 Specification Standard in section ***"Prior Authorization"***.

Question:
If the Prior Authorization Request Only Transaction is sent and the Prior Authorization is not assigned at that time, then if you send a Prior Authorization Inquiry Transaction, and if then the Prior Authorization is assigned, what type of Response Status will the claim or service receive? "A" Approved? Would you then need to send a regular billed claim with the Prior Authorization Segment included?

Response:
See Section 7.3 and Section 11 in Version 5 Specification Standard. See also Appendix C. Prior Authorization Clarifications in this document.

PRIOR AUTHORIZATION REQUEST AND BILLING TRANSACTION
RESPONSE STATUSES/PRIOR AUTHORIZATION NOT ASSIGNED/ASSIGNED

Question:
If the Prior Authorization Request and Billing Transaction is sent and the Prior Authorization is not assigned at that time, then does the transaction come back with a "C" Captured or an "F" Prior Authorization Deferred? What is the difference? Can a Prior Authorization be assigned if this transaction is a "C" Captured?

Response:
If the Prior Authorization is not assigned, the response could be "C" or "F". Refer to Question above answer.

Question:
If the Prior Authorization Request and Billing Transaction is sent and the Prior Authorization is not assigned at that time, then if you send a Prior Authorization Inquiry Transaction, and if then the Prior Authorization is assigned, what type of Response Status will the claim receive? "A" Approved or "P" Paid? Is it automatically billed?

Response:
If the processor's system automatically adjudicates the claim, and the claim is not rejected, a "P" Paid response is returned. Note: Some systems may require the submission of the claim in this scenario. See section 11 in Version 5 Specification Standard.

P/A REQUEST AND BILLING – PA NOT REQUIRED

Question:
If a pharmacy submits a Prior Authorization Request and Billing transaction and the processor determines that the billing part of the transaction doesn't require a prior authorization, what response should the processor return? If the processor returns a paid response, it is required to have the prior authorization assigned number and pertinent prior authorization information. If the billing didn't require a PA, how can they return the PA assigned number and pertinent information?

Response:

The Prior Authorization Request and Billing should be rejected in this scenario. For the processor to return a “P”aid response would mean the pertinent PA information is not returned (nor should it be) and this could cause confusion for the pharmacy system. Reject Code “3R ” (Prior Authorization Not Required) and “85 “ (Claim Not Processed) as well as any other pertinent reject codes should be considered.

P/A REQUEST AND BILLING - DEFERRED

Question:
If the processor returns a deferred response on a Prior Authorization Request and Billing transaction, is the processor required to hold the billing and process it if the prior authorization is approved?

Response:
The deferred response was requested by Medicaid agencies. Please consult the processor’s provider manual for further information.

It is noted in the Version 5 Editorial document, as a revision to the Telecommunication Standard Implementation Guide, “The processor responds with an "F" (Deferred) response that includes a Prior Authorization Number - Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor's provider manual for further information.”

REBILL TRANSACTIONS (B3, C3, N3)
DUPLICATE PROCESSING FOR ALL REBILL TRANSACTIONS

Question:
How do you handle duplicates in the case of a Rebill?

We received a request for clarification of a 'D' response for Rebill transactions. The request was regarding a '"B3"--Rebill (claim/service) but there are also "N3"--Information Reporting Rebill and "C3"--Controlled Substance Reporting Rebill. Per the Implementation Guide, a duplicate check is based on same Patient, Service Provider ID, Date of Service, Product/Service Reference Number, Prescription/Service Reference Number, and Fill Number. For a reversal, the duplicate check is based on the same Service Provider ID, Date of Service, Product/Service Reference Number, Prescription/Service Reference Number, and Fill Number. All rebills have an implied reversal.

Scenario:
Transaction 1 - A claim is submitted and paid by a processor.
Transaction 2 - The same claim is sent to the processor as a Rebill to correct the Prescriber ID. The processor receives the Rebill and processes the reversal and pays the claim with the different Prescriber ID.

There is a communication-level drop and the provider does not receive the response.

Transaction 3 - The provider sends the Rebill again. The processor applies the duplicate logic and returns a "D" (Duplicate of Paid) response. So far, the process works.

Transaction 4 - The same day the provider realizes that he had entered the wrong days supply and resubmits a Rebill of the same claim but with a corrected days supply.

The processor applies the duplicate logic and returns a "D" (Duplicate of Paid) response. It appears the only way to correct the day's supply is by submitting two transactions.

Discussion:
The correction of fields not included in the duplicate check may be made using the rebill transaction. Because rebills have an implied reversal, it appears that the duplicate value responses do not apply to rebill transactions. Since the same fields are

used for a duplicate check and the implied reversal exists, the same problem occurs for Information and Controlled Substance Reporting Rebills as well.

Every transaction has the chance of a communications drop, but in this case, the duplicate response is not needed for the resubmission due to a communications drop.

Response:
Therefore, based on discussions, the members determined that there is no business reason found for the duplicate responses for the rebill transactions. By having duplicate responses in rebills you take away the submitter's ability to modify a field that is not included in the duplicate field check.

The duplicate Transaction Response Status (112-AN) of “D” (Duplicate of Paid) and “Q” (Duplicate of Captured) on Claim/Service Rebill transactions (B3) are not needed.

The Transaction Response Status (112-AN) of “S” (Duplicate of Approved) and “Q” (Duplicate of Captured) for Controlled Substance Reporting Rebill transactions (C3) are not needed.

The Transaction Response Status (112-AN) of “S” (Duplicate of Approved), “Q” (Duplicate of Captured), and “D” (Duplicate of Paid) for Information Reporting Rebill transactions (N3) are not needed.

In the event that a duplicate response is returned, the claim will need to be reversed separately and then resubmitted.

MULTIPLE REBILL TRANSACTIONS IN A TRANSMISSION

Question:
What are the recommended guidelines for supporting multiple rebill (B3, N3, C3) transactions within a transmission?

Response:
A rebill transmission (B3) should follow a combination of the guidelines established in claim or service billing and claim or service reversals, since a rebill is a combination of a billing with an implied reversal. Reversal guidelines have been given. See section “***Claim or Service Reversal*”** in the ***Specifications***.

An information reporting rebill (N3) should follow a combination of the guidelines established in information reporting and information reporting reversals, since information reporting rebill is a combination of an information reporting with an implied reversal. Reversal guidelines have been given. See section "***Information Reporting Reversal*"** in the ***Specifications*.**
A controlled substance reporting rebill (C3) should follow a combination of the guidelines established in controlled substance reporting and controlled substance reporting reversals, since a controlled substance reporting rebill is a combination of a controlled substance reporting with an implied reversal. Reversal guidelines have been given. See section *"**Controlled Substance Reporting Reversal"*** in the ***Specifications*.**
See also "***Frequently Asked Question"*** "What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?" for guidelines on reversals.
See sections "***Duplicate***" and "***Duplicate Processing for all Rebill Transactions***" for more information.

REVERSAL TRANSACTION

CLAIM OR SERVICE REVERSAL TRANSACTION (B2)

FIELDS USED IN REVERSAL TRANSACTION

Question:
In Claim or Service Reversal Transaction (B2), what is the usefulness of fields other than Provider, Rx Number, and Date of Service?

Response:
The intention of Version 5 was to allow flexibility for trading partner needs. In a Claim or Service Reversal, in addition to the mandatory Transaction Header Segment and the Claim Segment, the Patient, Insurance, DUR/PPS, and Pricing Segments are optional. These optional segments allow the trading partners to use other information for tracking a reversal of a claim or service. A processor/PBM may need a Patient ID and Qualifier to track a business need not being met today for a reversal. DUR/PPS information might be sent to a processor/PBM to explain a reversal situation.

MULTIPLE CLAIM/SERVICE REVERSAL TRANSACTIONS WITHIN A TRANSMISSION

Question:
What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?

Response:
The Transaction Header Segment is required, which contains the routing and identification information – BIN Number, Version/Release Number, Transaction Code, Processor Control Number, Transaction Count, Service Provider ID and Qualifier, Date of Service.

Therefore, following the rules to correctly build a multi-reversal transmission, the reversal transaction(s) in this transmission must be

- in the same format (Version/Release Number) and
- sent to the same entity (processor or PBM using the BIN Number and Processor Control Number) and
- for the same pharmacy (Service Provider ID and Qualifier) and
- for the same date (Date of Service).

Optional segments such as the Patient and Insurance segments may be supported. If a processor/PBM needs this information to process a reversal, these segments can be used. Only one Patient and only one Insurance Segment should be submitted per transmission.

If a processor/PBM does not need the Patient and Insurance segments, but the pharmacy wishes to send it, the processor/PBM should ignore the optional information.

Date of Service (4Ø1-D1) is defined as “identifies date the prescription was filled or professional service rendered”. Therefore, since the date is in the Transaction Header segment that occurs once (at the transmission level), one to four transactions (at the transaction level) must be for the same date.

It is a recommended business practice that multiple claim or service reversal transactions in a transmission should be for the same patient.

The structure does support multiple claim or service reversals for the same processor/PBM, for the same pharmacy, for the same Date of Service, but for multiple patients. **However, it is recommended that a transmission containing multiple reversals for multiple patients *not* be supported.** Even though the structure supports reversals for multiple patients, the recommendation is that this not be supported.

As with all transmissions, the number of response transactions should match the number of request transactions. The processor/PBM should respond with the appropriate Transaction Response Status codes for the Transaction Count. For example if 3 reversal transactions are within a transmission (Transaction Count = 3), the processor/PBM should respond with a Transaction Count = 3 with three transaction responses, one for each reversal.

For Version 5.6 and higher, the Reject Code (511-FB) value “RV“ (Multiple Reversals Per Transmission Not Supported) can be used for Claim/Service Billing Reversals, Rebill transmissions, Controlled Substance Reporting Reversals, and Information Reporting Reversals if the processor does not support multiple reversal transactions within a transmission.

For Version 5.Ø-5.5, Reject Code (511-FB) value “RV“ was not yet created. Therefore, the recommendation is to use Reject Code (511-FB) values of “87” (Reversal Not Processed) and “A9” (M/I Transaction Count). The value of “PB” (Invalid Transaction Count For This Transaction Code) may also be used in conjunction with the other values.

See section "***Transaction Types*****"** subsection ***"Claim or Service Reversal",*** "***Transaction Request Diagrams*****"** and "***Transaction Response Diagrams*****"** in the ***Telecommunication Specifications***. See section "***Special Considerations – Transactions, Segments, and Fields*****"** in the ***Implementation Guide***. See section "***Segment Usage Matrices*****"** in the ***Implementation Guide***.

IMPLEMENTATION GUIDE

EXAMPLES

OPTIONAL FIELDS

Question:
In the Implementation Guide, several examples (section 7.3, 7.4, 7.7.3, 7.12.2) for Rx billing are missing the optional fields (i.e. qty dispensed, days supply) in the Claim Segment. Is this an oversight?

Response:
The omission of some “optional fields” in the Implementation Examples was intentional. We wanted to provide examples with some “optional fields” and omit other “optional fields” as would be the case in an actual implementation of the Version 5 Standard.

EDITORIAL CHANGES APPLICABLE TO ALL VERSION 5 IMPLEMENTATION GUIDES

CORRECTIONS

PRODUCT ID QUALIFIER OF "NDC"

Question:
In the Implementation Guide, whenever an NDC was used as the product ID qualifier (fields 436-E1 Product/Service ID Qualifier, 475-J9 DUR Co-Agent ID Qualifier, 552-AP Preferred Product ID Qualifier), the value in the examples is shown as Ø1 or 1. The actual value for NDC should be Ø3 per Appendix K.

Response:
You are correct in your statement. We will change this in the Implementation Guide. (The Implementation Guide Version 5.3 and forward have been updated. Please note this correction is applicable to all Version 5 Implementation Guides (Version 5.Ø and forward) as an editorial change.)

Question:
Should the Product/Service ID Qualifier in the Claim Segment in Compound examples be ØØ instead of Ø3?

Response:
That is correct. In the Implementation Guide, the examples "Compounded Rx Billing - Transaction Code B1 (Ø1)" and "Billing Resubmission w/DUR Resolution", in the Claim Segment, the Product/Service ID Qualifier (436-E1) incorrectly had a value of Ø3 (NDC). In a multi-ingredient compound claim, the Product/Service ID and Qualifier default to zeroes in the Claim Segment, per the Implementation Guide. The Compound Segment contains the actual ingredients in the Compound Product ID and Qualifier. This has been corrected in Versions 5.6 and above

SECTION 9 VERSION CHANGES VERSION 5.3 (PUBLISHED MAY, 2ØØØ)

In the Implementation Guide Section 9 Version Changes, the bullet "Miscellaneous NDC Provider Qualifier examples corrected" has been corrected to "Miscellaneous NDC Product/Service ID Qualifier examples corrected". See above question for more information. This has been corrected in Version 5.3 through Version 5.5.

TOTAL AMOUNT PAID (5Ø9-F9) CORRECTION

Question:
In the Implementation Guide for the example responses in sections 7.3.1, 7.7.1, 7.8.1, 7.9.1, 7.12.1 the Total Amount Paid (field 5Ø9-F9) does not appear to be accurate based on the Pricing Formula defined in sections 4.2.9 and 8.1Ø.

Response:
Thank you for bringing this to our attention. The Implementation Guides will be updated to reflect this correction. (The Implementation Guide Version 5.3 and forward have been updated. Please note this correction is applicable to all Version 5 Implementation Guides (V5.Ø and forward) as an editorial change.)

TYPOGRAPHICAL CHANGES

Numerous typographical errors were found in the Implementation Guide examples. These changes have been corrected in Version 6.Ø and may be used as reference in Version 5.1, since the changes do not affect new fields or values. For ease of reference, the changes noted reference the examples in Version 5.1 Implementation Guide. See section “Appendix A: Typographical Changes Made In Version 6.Ø”.

Question:
In the Version 5.1 Implementation Guide, Example 7.13.3 Reversal Accepted Response – Duplicate, is the Transaction Response Status of “D” correct?

Response:
No. The Transaction Response Status (112-AN) should be “S” for Duplicate of Approved. This change has been made to the Version 6 and above Implementation Guides.

ENHANCEMENTS

REFERENCES TO THE COMPOUND AND PRIOR AUTHORIZATION IMPLEMENTATION GUIDES

Please see the Telecommunication Implementation Guide Version 5.6 for changes that removed the references to the Compound Implementation Guide. Please see the Telecommunication Implementation Guide Version 7.Ø for the most recent clarifications to Prior Authorization transactions. (The Version 5.6 Implementation Guide incorporated the Prior Authorization Implementation Guide, which was supported in prior versions. However, Versions 7.Ø, 7.1 of the Implementation Guide contains the most complete clarifications and should be used as a reference for Prior Authorization Transactions in Version 5.1. See also Appendix C. Prior Authorization Clarifications.)

Text from prior versions of the Compound Implementation Guide and Prior Authorization Guide was incorporated into the Telecommunication Implementation document as appropriate. In the section “Request Transaction Segments and Fields”, subsections “DUR/PPS Segment” and “Compound Segment” have incorporated the pertinent information formerly found in the Compound implementation guide.

Two new frequently asked questions related to compounds were added to the Telecommunication Implementation Guide (“How do I enter an ingredient in a compound that does not have an identifier (for example water)?” and How do I bill for a partial fill of a compound?”).

Please note the membership approved a preferred method for billing multi-ingredient compound transactions. The recommended method is the billing of each ingredient using the Claim and Compound Segment.

The alternate methods include

1) Billing for the most expensive legend drug
2) Using Billing codes (999.. numbers)

ADDITIONAL INFORMATION ON MULTIPLE REVERSAL TRANSACTIONS IN A TRANSMISSION

In Version 5.6 Implementation Guide, verbiage for the support of multiple reversal transactions in a transmission has been added. This is to offer more clarification to the support of multiple reversals for Claim or Service Reversals, Controlled Substance Reporting Reversals, Information Reporting Reversals, and Rebill transactions.

Two frequently asked questions related to multiple reversal transactions in a transmission were added (“What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?” and “What are the recommended guidelines for supporting multiple rebill (B3, N3, C3) transactions within a transmission?”).

See section “Transaction Discussion”, subsection “Reversal Transaction” for frequently asked questions.

NOTABLE CLARIFICATIONS

PRIOR AUTHORIZATION CLARIFICATIONS

Please see “Appendix C. Prior Authorization Clarifications” for important information on the use of the Prior Authorization transactions.

EDITORIAL CHANGES APPLICABLE TO ALL VERSION 5 DATA DICTIONARIES

CORRECTIONS

APPENDIX F – VERSION 5.Ø REJECT CODES FOR TELECOMMUNICATION STANDARD

The following corrections were made to the Data Dictionary:

Reject Code	Explanation	Corrected Explanation	Field Number Possibly In Error	Corrected Field Number Possibly In Error
Ø1	M/I Bin	M/I Bin Number		
Ø2	M/I Version Number	M/I Version/Release Number		
Ø5	M/I Pharmacy Number	M/I Service Provider ID		
Ø6	M/I Group Number	M/I Group ID		
Ø7	M/I Cardholder ID Number	M/I Cardholder ID		
Ø9	M/I Birth Date	M/I Date Of Birth		
29	M/I Number Refills Authorized	M/I Number of Refills Authorized		
3N	M/I Prior Authorization Number Assigned	M/I Prior Authorization Number-Assigned		
38	M/I Basis of Cost	M/I Basis Of Cost Determination		
62	Patient/Card Holder ID Name Mismatch			Change Field Possibly In Error to 3Ø2-C2 (from 32Ø)
6C	M/I Other Payer ID Qualifier			Change Field Possibly In Error to 339-6C (from 442)
EM	M/I Prescription/Service Reference Number Qualifier			Change Field Possibly In Error to 455-EM (from 445)
PC	M/I Claim Segment	M/I Request Claim Segment		
PD	M/I Clinical Segment	M/I Request Clinical Segment		
PE	M/I COB/Other Payments Segment	M/I Request Coordination of Benefits/Other Payments Segment		
PF	M/I Compound Segment	M/I Request Compound Segment		

PG	M/I Coupon Segment	M/I Request Coupon Segment		
PH	M/I DUR/PPS Segment	M/I Request DUR/PPS Segment		
PJ	M/I Insurance Segment	M/I Request Insurance Segment		
PK	M/I Patient Segment	M/I Request Patient Segment		
PM	M/I Pharmacy Provider Segment	M/I Request Pharmacy Provider Segment		
PN	M/I Prescriber Segment	M/I Request Prescriber Segment		
PP	M/I Pricing Segment	M/I Request Pricing Segment		
PR	M/I Prior Authorization Segment	M/I Request Prior Authorization Segment		
PT	M/I Workers' Compensation Segment	M/I Request Worker's Compensation Segment		

APPENDIX M – VERSION MODIFICATIONS – VERSION 5.2

In the Data Dictionary dated June 2ØØØ, Appendix M. Version Modifications, Version 5.2 incorrectly listed all values for Measurement Dimension and Measurement Unit as being added. For Measurement Dimension, values 18-34 were added. For Measurement Unit, values 15-27 were added. This section was also missing a chart to show the new field Patient E-Mail Address (35Ø-HN) was added. This has been corrected in future versions.

DUR CO-AGENT ID

DUR Co-Agent ID (476-H6) had an incorrect Comment. The Comment said DUR Co-Agent ID was qualified by 475-9E. The Comment has been corrected to state it is qualified by 475-J9.

PRODUCT/SERVICE ID (4Ø7-D7)

Field Product/Service ID had an incorrect Comment sentence. The qualifier for NDC cited was Ø1=NDC. This has been changed to the following: “Comments: Qualified by ‘Product/Service ID Qualifier’ (436-E1) If ‘Product Service ID Qualifier’ (436-E1) is Ø3=NDC.”

REJECT CODE (511-FB) = EM

Appendix F Version 5 Reject Codes for Telecommunication Standard - Reject Code (511-FB) with a value of “EM” (Missing/Invalid Prescription Service Reference Number Qualifier) points to Field ID 445. It should point to Field ID 455.

REJECT CODE (511-FB) = EF

Appendix F Version 5 Reject Codes for Telecommunication Standard - Reject Code (511-FB) with a value of “EF” (Missing/Invalid Compound Dosage Form Description Code). Corrected the spelling of “Descriptin”.

REJECT CODE (511-FB) = 4E

Appendix F Version 5 Reject Codes for Telecommunication Standard - Reject Code (511-FB) with a value of “4E” (Missing/Invalid Primary Care Provider Last Name) points to Field ID 57Ø. It should point to Field ID 47Ø.

VERSION/RELEASE NUMBER (1Ø2-A2) = 51

In the Data Dictionary dated September 1999, the value 51 is missing from the list of values for the Version/Release Number. This has been corrected in future versions.

EDITORIAL CHANGES APPLICABLE TO ALL VERSION 5 SPECIFICATIONS

CORRECTIONS

SECTION 8.2.2.2 COUNTER FIELDS

In Version 5.3 and 5.4 Specifications, the table in section 8.2.2.2 Counter Fields was changed. In the table showing count and counter usage, the Diagnosis Code Count was incorrectly represented. An additional row with Diagnosis Code Qualifier was added. For a count field repetition, the Diagnosis Code Qualifier and Diagnosis Code repeat the number of times the Count specifies.

SECTION 1Ø.4 DIAGRAM FOR TWO BILLING TRANSACTIONS, SECTION 1Ø.5, AND SECTION 1Ø.6

In Version 5.6 Specifications, section 1Ø.4 Diagram For Two Billing Transactions, section 1Ø.5 Diagram For Three Billing Transactions, and section 1Ø.6 Diagram For Four Billing Transactions incorrectly lists the Compound Segment in the second, third, and/or fourth claim/service. This was an error in the diagrams. Billing for multiple ingredients (compounds) transactions may occur only once within a transmission. Multiple ingredient (compound) transactions are limited to one transaction within a transmission.

SECTION 12.6 GENERAL INFORMATION FOR TRANSMISSION ACCEPTED/TRANSACTION REJECTED

In Version 5.5 Specifications, section 12.6 General Information For Transmission Accepted/Transaction Rejected Response was slightly modified. In previous releases, the Response Insurance, Response Pricing, and Response Prior Authorization were listed as not used. This section now correctly notes the Response Pricing and Response Prior Authorization as the two segments not used. This has been modified to match the Response Segment Matrices in the Implementation Guide.

GENERAL QUESTIONS

DOCUMENTATION HISTORY

DOCUMENTATION DATES

Question:
Where do I obtain publication date information of the various version/releases of the Telecommunication Standards?

Response:
On the NCPDP website, in the Members section, under Work Groups, Maintenance and Control, is a document section titled "Standard and Dictionary Usage Matrix". This document lists all of the NCPDP standards and implementation guides and their status and approval dates.

NO LONGER SUPPORTED FIELDS

PRIOR AUTHORIZATION/MEDICAL CERTIFICATION CODE AND NUMBER

Question:
Some fields are no longer supported in Version 5. If I was using one of these fields, is there an alternate field where the same data can be found, specifically Prior Authorization/Medical Certification Code and Number?

Response:
With analysis by the membership, fields that were deleted were determined to be either not used, or not used as intended and there were better alternatives. Information on deleted or renamed fields is available in the Data Dictionary.

Regarding the Prior Authorization/Medical Certification Code and Number, two new fields are to be used. Prior Authorization Type Code (461-EU) contains the values originally found in the Code of deleted field 416. Prior Authorization Number Submitted (462-EV) should be used for the Number of deleted field 416.

VERSION 5 SURVEY

AN ADDITIONAL SURVEY?

Question:

I thought the Version 5 surveys and the summarization of this information very useful. Does NCPDP have any plans to support another survey now that Version 5.1 is part of the HIPAA regulations?

Response:
NCPDP maintains a spreadsheet called “State of the States”. WG1 Telecommunication now maintains a tab on this sheet for commercial (non-Medicaid) processors who wish to publish their intentions of Telecommunication Standard Version 5.1 and Batch 1.1. WG9 Government Programs maintains a tab on this sheet for Medicaid states that wish to publish their intentions.

WHERE DO I FIND

Please see “Appendix E. Where Do I Find” for information on where to find various subjects in the NCPDP documents.

NCPDP BATCH STANDARDS

RESPONSE FORMAT

Question:
When responding to a Batch Standard Version 1.1 transmission is the response format required the same as the response for Telecommunication Standard Version 5.1?

Response:
Yes. The format of the Batch Standard request and response is based on the Telecommunication standard. The Telecommunication Standard Version 5.1 billing claim response would be "wrapped" with the Batch Standard Version 1.1 Header/Detail/Trailer format (envelope).

SEGMENT DEFINITION

BATCH STANDARD SEGMENT USAGE DIFFERENT THAN TELECOMMUNICATION STANDARD?

Question:
If a processor is using both the Telecommunication Standard Version 5.1 and Batch Standard Version 1.1 can they define different segments and qualifiers to be used in each standard? How would that be communicated to their Trading Partners?

Response:
Yes, via payer sheets, etc.

TRANSACTION PROCESSING

BATCH PROCESSING – REJECT

Question:
Does the logic for transmission reject apply to Batch Standard Version 1.1? Specifically if the transmission is rejected does it require that all transactions be marked as rejects as well?

Response:

If a reject occurs at the Required Transaction Header Section level of the batch file, the entire batch is rejected (see Batch Implementation Guide). If a reject occurs in the Detail Data Record within the Batch file, then the detail record is rejected. The Detail Data Record may be rejected due to the batch structure (Text Indicator, Segment Identifier, or Transaction Reference Number with some problem, or it may be rejected due to syntax or processing of the NCPDP Data Record.

Once the processing of the NCPDP Data Record occurs, the same structure and syntax rules apply as in the Telecommunication Standard Version 5.1 (for example). As processing of the NCPDP Data Record occurs, the claim or service (for example) may be rejected for various reasons. Note that within the NCPDP Data Record, the transmission level/transaction level applies where there may be one to four transactions within the transmission of one NCPDP Data Record within the Detail Data Record.

For example, the file may contain the following:
Required Transaction Header Section
Detail Data Record
Containing one NCPDP Data Record
Containing from one to four claim/service transactions

The NCPDP Data Record in the Batch Standard is the same as the “transmission” level in the Telecommunication Standard. The statement above “containing from one to four claim/service transactions” is the same as the discussion in the Telecommunication Standard about multiple claims or services per transmission (using the Transaction Count field).

RESPONSE TIME

Question:
Is there a HIPAA mandate as to what the response time should be on a Batch Standard Version 1.1 transmission?

Response:
No. Quote from the HIPAA Administration Simplification website (http://aspe.hhs.gov/admnsimp/):

> ‘45 CFR 162.925 states "a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction." If the standard transaction (e.g., ASC X12N 27Ø/271) is offered in a batch (non-interactive) mode, the health plan has to offer the same or higher level of service as it did for a batch mode of transaction before the standards were implemented by the plan. If a health plan offers the transaction in a real time (interactive) mode, the level of service has to be at least equal to the previously offered level for a real time mode of

transaction. If a transaction is offered through Direct Data Entry (DDE), the level of service, again, has to be at least equal to the level offered for the DDE transaction before implementation of the HIPAA standard."'

NCPDP BATCH STANDARDS - MEDICARE-RELATED QUESTIONS

This section was added to provide guidance for a uniform processing of Medicare claims. Needs of Medicare were not brought forward for inclusion into Batch Standard Version 1.1, so solutions were created for claims to be processed in this environment until permanent solutions could be found. This section should be used in conjunction with program memorandums or guidance CMS publishes.

BATCH RESPONSE

Question:
Will Medicare generate batch responses for both accepted and rejected NCPDP claims?

Response:
A Batch 1.1 response will be generated for each claim.

COORDINATION OF BENEFITS

Question:

Will Medicaids be expected to respond to the Batch 1.1 transactions submitted by the DMERCs? If so, will the Medicaid response be to the DMERC or the provider? Or, will the 835 transaction to the provider be sufficient?

Response:

Yes. Medicaid will be generating a batch file containing a response for each request since it is required in the NCPDP Batch Standard Implementation Guide. The response file will be sent back to the submitter, which in this case, is Medicare. Medicaid would send the appropriate ASC X12N 835 transaction to the provider**.**

COMPOUNDS

SUPPORT OF MODIFIER

Question:

Question from Medicare - How do we support the modifiers for compounds used in Medicare now?

Response:

Per the NCPDP Telecommunication Standard Implementation Guide, there is no order to the list of compounds when reporting using the Compound Segment. Medicare needs to link the KP modifier to a specific compound ingredient, the Compound Ingredient Basis of Cost Determination, field 49Ø-UE, will be used to identify the ingredient that has the KP modifier. For that ingredient this field would have a value of "Ø9" = Other. The use of the '"Ø9" would be only for Inhalation Compounds.

Since this is a temporary solution, the recommended permanent solution would be to add a new field to the Compound Segment. The field would have a situational field for Modifier Count and a situational and repeating field for Modifier. The recommended repetitions would be 8. This solution would need to be approved in a future version.

COMPOUND INGREDIENT DRUG COST CALCULATION

Question:

Since the DMERC system will generate a line item for each ingredient, the total of the Compound Ingredient Drug Cost would be used rather than the Gross Amount Due to pay the claim. Is this acceptable?

Response:

This is acceptable since a dispensing fee is paid for only specific procedures and the DMERC will take any fee submitted but will not pay it unless it is for a procedure for which they pay a dispensing fee.

NDC SUPPORT

Question:

What if one of the ingredients in the compound is not an NDC? Would the claim be rejected when the NDC validity was edited?

Response:

Medicare will support that if an NDC was not found on their files and it appeared in the Compound Segment, the claim would not reject for invalid NDC. It was suggested that Medicare should support inert ingredients, since the pharmacies may submit them in compounds.

TYPE OF COMPOUNDS

Question:

How are Nebulizer Compounds identified from Immunosuppressive Compounds?

Response:

The Compound Route of Administration, field 452-EH should be used since it is the route of administration of the complete compound mixture. For Medicare, the value of 3=Inhalation would identify Nebulizer Compounds and the value of 11=Oral would identify Immunosuppressive Compounds.

INDICATE MEDICAID COVERAGE?

Question:

Because some Medicaid States do not submit Medicaid eligibility files to the Medicare carrier, an indication is needed on the NCPDP claim that the patient has Medicaid coverage in order to cross the claims over to Medicaid. Where would this information be populated?

Response:

The Group ID (3Ø1-C1) is to be used to indicate Medicaid coverage. Since this is an alphanumeric field, a unique entry will be used to distinguish a Medicaid indicator and an OCNA number. 1Ø bytes of the 15-byte Group ID field will be used with a 2-character State Postal Code followed by the word “Medicaid”. So a Texas Medicaid claim would show, “TXMEDICAID”, in the Group ID.

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new field “Medicaid Indicator” added for a future version of the NCPDP standard.

MEDICARE CROSSOVER CLAIMS

SUPPORT OF ALLOWED AMOUNT, DEDUCTIBLE AMOUNT, CO-INSURANCE AMOUNT AND CO-PAYMENT AMOUNT

Question:

Claims submitted to Medicare for dual eligible clients (Medicare and Medicaid) will be crossed-over to the Medicaid States by the DMERCs. The Medicaid States have indicated that they need four fields besides the Medicare Paid Amount coming from the DMERCs—1) Medicare’s Allowed Amount, 2) Medicare’s Deductible Amount, 3) Medicare’s Co-insurance Amount and 4) Co-payment Amount. Where will this data be populated?

Response:

For Cross Over claims, the following values should be used in the Other Payer Amount Paid Qualifier (342-HC) field:

Medicare Allowed Amount = 'Ø7'
Medicare Paid Amount = 'Ø8'
Deductible Amount = '99'
Coinsurance Amount= '99'
Copayment Amount = '99'

For the reiteration of value ‘99’, the order should always be Deductible Amount followed by Coinsurance Amount and Co-payment Amount. Of these three Amounts, nothing below the last Amount that is needed to be populated should be sent but everything above the last Amount that is needed to be populated, should be sent. In other words, if there is a Deductible Amount and Co-payment Amount to be sent, Coinsurance Amount will occur after Deductible Amount but with zero $ amounts. Likewise, if there is a Deductible Amount to be sent but no Coinsurance or Co-payment Amounts, the “99” values should not be repeated for Coinsurance and Co-payment Amounts. This is just not a process confined to Medicare passing to Medicaids---Medicare will use this to pass to other insurers.

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new values for Primary Paid Amount, Primary Allowed Amount, Deductible Amount, Coinsurance Amount, and Copay Amount added to the Other Payer Amount Paid Qualifier (342-HC) field for a future version of the NCPDP standard.

MEDIGAP COVERAGE?

Question:

How will we determine if a NCPDP claim is Medigap? There doesn't seem to be a code in the COB segment indicating that the beneficiary has Medigap coverage.

Response:

Medicare requested the support of fields for Medigap Policy Number (OCNA number) and Medicare ID Number (cardholder number). The Group ID (3Ø1-C1) (which is not used by Medicare) is not large enough to support the Medigap Policy Number. Upon review, the Alternate ID (33Ø-CW) is to be used for the Medigap Policy Number, which is 2Ø-bytes and is part of the Claim Segment. The Medicare ID Number is to be placed in the Cardholder ID (3Ø2-C2).

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a Medigap ID field added to a future version of the NCPDP standard. It was suggested that the DERF request addition of this new field to the Insurance Segment.

MEDICARE REVERSAL TRANSACTIONS

Question:

Will the DMERCs be accepting and processing reversal transactions? If so, are they planning on sending these transactions to Medicaids through the crossover process?

Response:

No. The DMERCs will not process reversal transactions for NCPDP or 837 claims.

MEDICARE SECONDARY PAYER (MSP)

Question:

Besides the Amount Paid, Medicare requires that the Original Submitted Amount, the Allowed Amount and Obligated to Accept Amount (same as the Contract Amount) fields be submitted to them from the pharmacy. This situation would be when Medicare is the secondary payer (MSP). Where would this data be populated?

Response:

The Gross Amount Due (43Ø-DU) field from the Pricing Segment will be used by the pharmacy to submit the Original Submitted Amount. Other data will be sent in the COB/Other Payments Segment. Medicare will utilize different qualifier values in Other Payer Amount Paid Qualifier (342-HC). When the qualifier is "Ø7" (Drug Benefit), contract amount will be sent in Other Payer Amount Paid (432-DV). When the qualifier is "Ø8" (Sum of All Reimbursement), Primary Paid Amount will be sent in 432-DV. Finally, when the qualifier is 99 (Other), Primary Allowed Amount will be sent in 432-DV.

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new values for Obligated to Accept/Contract Amount, Primary Paid Amount, Primary Allowed Amount, Deductible Amount, Coinsurance Amount, and Copay Amount added to the Other Payer Amount Paid Qualifier (342-HC) field for a future version of the NCPDP standard.

NDC/HCPCS, UNIT OF MEASURE (6ØØ-28), AND RATIO

Question:

For number of services - is this the field quantity dispensed 442-E7 in the Claim Segment? Do we also need to look at Unit Dose Indicator (429-DT) and Unit Of Measure (6ØØ-28) fields in the Claim Segment?

Response:

CMS provides the DMERCs with a chart containing a ratio for each NDC that is used to divide into a field to determine the number of HCPCS "services". CMS would use the Quantity Dispensed (442-E7) to be divided by the ratio to get the number of services.

Question:

Will the Ratio expressed in the Unit of Measure (6ØØ-28) used by NCPDP be converted to the Unit of Measure used by the DMERCs?

Response:

Yes.

USE OF PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION (498-PP)

(See format for this field under Certificate of Medical Necessity (CMN Form))

Question:

There is a need to send narrative information on a claim that also has a CMN. Besides the need to send CMN information only with no narrative information, there is also a need to send only narrative information with no CMN. How will this be accomplished?

Response:

The first 3 bytes of the 498-PP Prior Authorization Supporting Document field will be an Authorization Information Qualifier with the following values and descriptions:

CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information
NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information
NCM - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new Narrative Segment added for a future version of the NCPDP standard.

Question:

Facility name, street address, city, state and zip and Representative Payee information are needed. Currently the facility name and address are being mapped from the authorized representative fields on the Prior Authorization Segment, when the string 'CMN' is in positions 1 thru 3 of the 5ØØ byte narrative field. However, if a Prior Authorization Segment is sent without the string 'CMN', then the

data in the authorized representative fields is mapped to the rep. payee fields on the claim. What if the claim has both rep. payee information and requires the facility name and address? Also, what if facility name and address is needed, but a CMN is not?

Response:

This information will go in the Prior Authorization Supporting Documentation (498-PP) field. Currently the first 3 bytes of that field would be used as a Qualifier to indicate what would be populated in the field, the CMN would be in bytes 4-18Ø and the Narrative Information would be in bytes 181-26Ø. The Facility Name, address, city, state and zip code would start with byte 261. (The permanent solution would be to request new fields for Facility for a future version/release of the standard.)

Question:

How do the mandatory fields within the Prior Authorization Segment relate to the use of the PA Supporting Documentation (498-PP) field?

Response:

The mandatory fields must be consistently used. The mandatory fields are Segment Identification (111-AM), Request Type (498-PA), Request Period Date-Begin (498-PB), Request Period Date-End (498-PC), and Basis of Request (498-PD). Besides the Segment Identification the remaining fields are relevant for the Narrative Information and the Facility Information. For Narrative Information and Facility Information the Request Type may be any of the three values (Initial, Reauthorization, and Deferred), the Request Period Date-Begin and Request Period Date-End should default to the Date of Service or the date of submission (DMERC will indicate which to the provider), and the Basis of Request should always be Plan Requirement.

Question:

May modifiers that are needed on compounds (other than inhalation) be added to the PA Supporting Documentation Field (498-PP)? This relates to Medicare Part B and not CMN forms. The following are examples:

GA - Waiver of Liability statement on file
EY - No physician or other licensed health care provider order for this item or service
GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
GZ - Item or service expected to be denied as not reasonable or necessary
QQ - Claim submitted with a written statement of intent

QV - Item or service provided as routine care in a Medicare qualifying clinical trial

Response:

A new identifier will be added to the Authorization Information Qualifier, which are the first three bytes of the PA Supporting Documentation field, for the CMN current solution. (The future fix to this is the request for the addition of new fields, Procedure Modifier and Modifier Count, to be added to the Compound Segment.)

Note: Current Values Are:

CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information
CNA - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information
CFA - Indicates that the Supporting documentation that follows is both Medicare required CMN and Facility Name and address information
CNF - Indicates that the Supporting documentation that follows is Medicare required CMN information, narrative information, and Facility Name and address information
FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information
FAN - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information and narrative information
MMN - Indicates that the Supporting documentation that follows is Medicare modifier information and CMN information.
MNA – Indicates that the Supporting documentation that follows is Medicare modifier, Medicare CMN, and Narrative information.
MFA – Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, and Facility Name and Address.
MNF- Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, Narrative, and Facility Name and Address
MAC - Indicates that the Supporting documentation that follows is Medicare Modifier information and Facility Name and Address
MAN - Indicates that the Supporting documentation that follows is Medicare Modifier information, Facility Name and Address, and Narrative information.
MAR - Indicates that the Supporting documentation that follows is Medicare Modifier information and Narrative information.
NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information

UNIQUE FIELD NEEDS

Question:

The field Patient Location (3Ø7-C7) on the Patient Segment does not have a value to indicate End Stage Renal Disease Treatment Facility (CMS POS = 65) that has special implications for a DMERC claim. Where can this information reside?

Response:

Submission Clarification Code (42Ø-DK) values of either 2=Other Override or 99=Other should be used to indicate that this is an ESRD facility. (A new value for ESRD Facility needs to be added to Patient Location (3Ø7-C7) in a future version of the standard.

CERTIFICATE OF MEDICAL NECESSITY (CMN) FORM

Following is a table that defines the mapping of data elements from the current Medicare forms to the NCPDP Version 5.1 Telecommunication Standard:

CMN field	5.1 field
Certificate Type/Date - Initial	498-PA Request Type-Initial
Certificate Type/Date - Revised	498-PA Request Type- Deferred
	498-PB Request Period Beginning Date
Certificate Type/Date – Re-certification	498-PA Request Type-Reauthorized
	49Ø-PC Request Period End Date
Patient First Name	31Ø-CA Patient First Name
Patient Last Name	311-CB Patient Last Name
Patient Street Address	322-CM Patient Street Address
Patient City	323-CN Patient City
Patient State	324-CO Patient State
Patient Zip	325-CP Patient Zip
Patient Telephone Number	326-CQ Patient Telephone Number
Patient HICN # (Medicare ID Number)	3Ø2-C2 Cardholder ID
Supplier NSC # (Medicare Supplier #)	2Ø2-B2 Service Provider ID Qualifier (Ø4)
	2Ø1-B1 Service Provider ID (Medicare)
Place of Service (See DMERC Supplier list)	3Ø7-C7 Patient Location
Facility Name	336-8C Facility ID
Physician Name	427-DR Prescriber Last Name (only)

CMN field	5.1 field
Physician Telephone Number	498-PM Prescriber Phone Number
Physician UPIN	466-EZ Prescriber ID Qualifier (Ø6)
	411-DB Prescriber ID (UPIN)
Patient Date of Birth	3Ø4-C4 Date Of Birth
Patient Height	466-H2 Measurement Dimension (16)
	497-H3 Measurement Unit (Ø1 - Inches)
Patient Weight	466-H2 Measurement Dimension (14)
	497-H3 Measurement Unit (Ø3 - Pounds)
Patient Gender	3Ø5-C5 Gender
HCPCS Code	4Ø7-D7 Product Service Id
	436-E1 Product Service ID Qualifier (Ø9)
Diagnosis code (up to 3 occurrences)	424-DO Diagnosis code (ICD9)
	491-VE Diagnosis Code Count (handles 3)
	492-WE Diagnosis Code Qualifier (Ø1)
Name of Person Answering Questions	498-PE Authorized Rep First Name
	498-PF Authorized Rep Last Name
Supplier's Charge	426-DQ Usual & Customary Charge

Those fields that did not map to an existing NCPDP Version 5.1 Telecommunication Standard/Batch 1.1 field, were placed in the **PA Supporting Documentation (498-PP)** field with the following format:
Note: Starting with position 181, the following format also includes solutions to processing of Medicare claims.

Description	Field Format	Start	Length	Values	Comments
498-PP Prior Auth Supporting Document		**1**	**5ØØ**		
Data Elements common to all CMNs					
Authorization Information Qualifier	AN	1	3	CMN - Certificate of Medical Necessity CNA - Medicare CMN and Narrative CFA - Medicare CMN and Facility Name and Address CNF - Medicare CMN, Narrative, and Facility Name and Address	CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information CNA - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information CFA - Indicates that the Supporting documentation that follows is both Medicare required CMN and Facility Name and address information

				FAC - Facility Name and Address FAN - Facility Name and Address and Narrative MMN – Modifier and Certificate of Medical Necessity MNA – Modifier and Medicare CMN and Narrative MFA – Modifier and Medicare CMN and Facility Name and Address MNF – Modifier and Medicare CMN, Narrative, and Facility Name and Address MAC – Modifier and Facility Name and Address MAN – Modifier and Facility Name and Address and Narrative MAR – Modifier and Narrative NAR - Narrative	CNF - Indicates that the Supporting documentation that follows is Medicare required CMN information, narrative information, and Facility Name and address information FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information FAN - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information and narrative information MMN - Indicates that the Supporting documentation that follows is Medicare modifier information and CMN information. MNA – Indicates that the Supporting documentation that follows is Medicare modifier, Medicare CMN, and Narrative information. MFA – Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, and Facility Name and Address. MNF- Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, Narrative, and Facility Name and Address MAC - Indicates that the Supporting documentation that follows is Medicare Modifier information and Facility Name and Address MAN - Indicates that the Supporting documentation that follows is Medicare Modifier information, Facility Name and Address, and Narrative information. MAR - Indicates that the Supporting documentation that follows is Medicare Modifier information and Narrative information. NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information
Form Identifier	AN	4	6	08.02 - Immunosuppressive Drug CMN or DIF	
Ordering Physician First Name	AN	1Ø	12		
Ordering Physician Address	AN	22	3Ø		
Ordering Physician City	AN	52	2Ø		
Ordering Physician State	AN	72	2		
Ordering Physician Zip	AN	74	15		
Certificate on File Indicator	AN	89	1	Y or N	This certifies that the supplier has a paper copy of the CMN or DIF on file available for the DMERC to review if necessary

Signature Date	DT	9Ø	8	CCYYMMDD	Date the Supplier signed the CMN or DIF form
Question Ø1A - HCPCS	AN	98	11	valid drug HCPCS code	Drug prescribed
Question Ø1B - MG	N0	1Ø9	4	ØØØ1 thru 9999	Dosage in Milligrams of the Drug prescribed in question Ø1A
Question Ø1C - Times Per Day	N0	113	2	Ø1 - 99	Frequency of administration of Drug Prescribed in question Ø1A
Question Ø2A - HCPCS	AN	115	11	valid drug HCPCS code spaces are valid	Drug prescribed
Question Ø2B - MG	N0	126	4	ØØØØ thru 9999	Dosage in Milligrams of the Drug prescribed in question Ø2A
Question Ø2C - Times Per Day	N0	13Ø	2	ØØ - 99	Frequency of administration of Drug Prescribed in question Ø2A
Question Ø3A - HCPCS	AN	132	11	valid drug HCPCS code spaces are valid	Drug prescribed
Question Ø3B - MG	N0	143	4	ØØØØ thru 9999	Dosage in Milligrams of the Drug prescribed in question Ø3A
Question Ø3C - Times Per Day	N0	147	2	ØØ – 99	Frequency of administration of Drug Prescribed in question Ø3A
Question Ø4	AN	149	1	Y or N	Has the Patient had an organ transplant that was covered by Medicare?
Question Ø5A	AN	15Ø	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant) Required if the answer to question 4 is Y

Question Ø5B	AN	151	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question Ø5C	AN	152	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question 11	DT	153	8	CCYYMMDD	Date Patient was discharged from the hospital following this transplant surgery
Question 12	AN	161	1	Y or N	Was there a prior transplant failure of this same organ?
Filler	AN	162	19		Space for possible expansion of data required for Immunosuppressive DIF
Data Elements for Medicare Required Narrative Data					
Narrative	AN	181	8∅	Free Form Text	
Data Elements for Medicare Required Facility name and Address Data					**Required when Patient Location is not Ø1 – Home**
Facility Name	AN	261	27		

Facility Address	AN	288	3∅		
Facility City	AN	318	2∅		
Facility State	AN	338	2		
Facility Zip	AN	34∅	15		
Data elements for Modifier	**AN**	**355**	**25**	**Ø1-25**	**Indicate the 2-byte ingredient number followed by the two-position modifier.**
Filler	AN	38Ø	121		For future use.

MODIFICATIONS TO THIS DOCUMENT

VERSION 2.Ø

Version 2.Ø includes the section Mandatory Fields First In Segments.

It also includes the section Mandatory Qualifiers And Fields – Usage of Default Values.

Version 2.Ø also includes the editorial change to the Specification. The “Diagram for Two (Three or Four) Billing Transactions incorrectly lists the Compound Segment. This was incorrect in the diagrams. Billing for multiple ingredients (compounds) transactions may occur only once within a transmission.

The section “References To The Compound and Prior Authorization Implementation Guides” has been added to the section “Editorial Changes Applicable To All Version 5 Implementation Guides”. This information has also been added to the Version 5.6 Implementation Guide. The information is applicable to all Version 5 Implementation Guides.

The section “Additional Information On Multiple Reversal Transactions In A Transmission” has been added to the section “Editorial Changes Applicable To All Version 5 Implementation Guides”. This information has also been added to the Version 5.6 Implementation Guide. The information is applicable to all Version 5 Implementation Guides.

The section “Section 9 Version Changes Version 5.3 (Published May, 2ØØØ)” has been added to the “Editorial Changes Applicable To All Version 5 Implementation Guides” section. This shows the correction to a bullet for the Product/Service ID Qualifier of “NDC”.

In the “Response Pricing Segment”, “Other Payer Amount Recognized (556-J5)” section of this document, the section “Will It Contain The Sum Of All Occurrence Amounts?” has been added.

In the “Transaction Header Segment” section, the section “Software Vendor/Certification ID (11Ø-AK)”, “Usage” with the question “How is Transaction header field 11Ø-AK used?” has been added.

In the “Claim Segment” section, “Submission Clarification Code (42Ø-DK)”, “Value 9 Usage” has been added with the question “In the Claim Segment field 42Ø-DK, code 9: is this used for encounter data from providers in a managed care network? If not, what is the purpose of this code?”

In the “Transmission/Transaction Syntax” section, the section “Zero Dollar Amounts” has been added with the question “How Should Zero Dollar Amounts Be Handled In A Variable Transaction?” The section “Alphanumeric Field Expansion” has been added with a question.

The section “Response Status Segment” has been added with a question about Reject Code (511-FB).

The section “Response Message Segment” has been added with a question about Additional Message Information and Message field usage.

In the section “Editorial Changes Applicable To All Version 5 Data Dictionaries”, the section “Version/Release Number (1Ø2-A2) = 51” has been added. The section “Product/Service ID” has been added.

Also in this same section, “Appendix M – Version Modifications – Version 5.2” has been added.

In the section “General Questions”, the section “Documentation History”, “Documentation Dates”, question “Where do I obtain publication date information of the various version/releases of the Telecommunication Standards?” has been added.

VERSION 3.Ø

In the section “Editorial Changes Applicable to all Version 5 Implementation Guides”, “Corrections”, “Product ID Qualifier Of “NDC”, a correction has been added clarifying the Product/Service ID Qualifier in the Compound examples in the question “Should the Product/Service ID Qualifier in the Claim Segment in Compound examples be ØØ instead of Ø3?”

The section “Pricing Segment”, “Sales Tax Fields”, “Usage” has been added with the question “How are the Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Percentage Sales Tax Rate Submitted (483-HE), and Percentage Sales Tax Basis Submitted (484-JE) used?”

Numerous editorial corrections were made to examples in the Implementation Guide. See section “Editorial Changes Applicable to all Version 5 Implementation Guides”, “Corrections”, “Typographical Changes”.

“Appendix B. Coordination Of Benefits Explanation For Version 5.1” was added to provide information on billing COB in Version 5.1.

The section “Notable Clarifications” “Prior Authorization Clarifications” has been added to the section “Prior Authorization Transactions”. The section “Notable Clarifications” “Prior Authorization Clarifications” has also been added to “Enhancements” “References to the Compound and Prior Authorization Implementation Guide”. This section has been modified to reflect that although Telecommunication Implementation Guide Version 5.6 had changes to incorporate the Prior Authorization Implementation Guide information, Appendix C and Versions 7.Ø, 7.1 should be used for their breadth of information.

Please note the membership approved a recommended method of processing for Compound (multi-ingredient) prescriptions.

Please see “Appendix C. Prior Authorization Clarifications” for important information on the use of the Prior Authorization transactions.

The response in the section “An Additional Survey?” has been updated to reflect the WG1 Telecommunication and WG9 Government Programs ongoing efforts.

VERSION 4.Ø

Version 4.Ø includes “Appendix D. Billing For Compounds” that contains more information about processing Compound transactions. This information is included in the Telecommunication Implementation Guide Version 5.6 and above. This information can be used with any Version 5 and above implementation, as it is clarification and does not affect the specifications.

In example 7.18.1, the Authorization Number (5Ø3-F3) was corrected (see Appendix C. Prior Authorization Clarifications). Information was also added to Section 4.2.12 Prior Authorization Segment in the Telecommunication Implementation Guide Version 7.1 includes information for Request Type (498-PA) = “2” (Reauthorization). See Appendix C. Prior Authorization Clarifications.

VERSION 5.Ø

The section “Compound/Multi-Ingredient Processing” has been added with questions on Quantity Dispensed and rejections. The sections “Business Function of Capture” and “Pricing Guidelines” have also been added.

A correction to Example 7.13.3 Reversal Accepted – Response Duplicate from the Version 5.1 Implementation Guide has been noted. See “Editorial Changes Applicable to all Version 5 Implementation Guides”, “Corrections”, for the question “In the Version 5.1 Implementation Guide, Example 7.13.3 Reversal Accepted Response – Duplicate, is the Transaction Response Status of “D” correct?”

VERSION 6.Ø

Additional questions were added to the document for Version 6.Ø. The section “Rebill Transactions (B3, C3, N3)”, “Duplicate Processing for All Rebill Transactions” with the question: “How do you handle duplicates in the case of a Rebill?” has been added.

In the “Response Header Segment” section, the subsection “Response Header Segment Fields Not Modified From Transaction Header Segment”, “Usage” has been added with the question “Should the fields submitted in the Transaction Header Segment on a request be returned without modification on the Response Header Segment? (Should they be mirrored?)”

Section “Response Status Segment” contains a new subsection “Response With Accepted And Rejected Information”, “Allowed?” with the question “Can a response transaction contain accepted and rejected information? For example, on an RX Billing (B1), could the response be returned with a Transaction Response Status of “P” (Paid) and in the Response Status Segment, Reject Code and Count fields be included to relay information? Or in another example, could a Reversal (B2) response be “A” (Approved) and Reject Code and Count fields be included?”

In the section “Compound/Multi-Ingredient Processing”, a new subsection “DUR For Compounds”, “Processing” has been added with the question “On compounded claims, does DUR "hit" each drug within the compound? “ A new subsection has also been added “Order of Compound Ingredients”, “Submitted in highest quantity order?” with the question “On compounded claims, does DUR "hit" each drug within the compound?
Should compound ingredients be put in highest usage amount order? (i.e., product A 8Ø%, product B 1Ø%, product C 1Ø%). “

In the section “Claim Segment”, a new subsection “Product/Service ID (4Ø7-D7)”, “Format and Usage” was added with a question about the usage of the 11-digit format of the codes.

In section “Transmission/Transaction Syntax”, a new subsection “Field Size Different In HIPAA Standards”, “Usage” was added with the question “The field sizes in ASC X12N are larger than in NCPDP Telecommunication Standard Version 5.1. An example would be Subscriber ID in the 834 standard at 3Ø bytes and the NCPDP Cardholder ID at 2Ø bytes. What field length should be used? “

A new section was added to the document “NCPDP Batch Standard” to answer questions for the implementation of the Batch Standard, with the Telecommunication Standard used as the NCPDP Data Record within the Detail Data Record.

VERSION 7.Ø

In Version 7.Ø of this document, the subsection “Count and Counter Information“ was added to the section “Transmission/Transaction Syntax”.

VERSION 8.Ø

Additional questions from the Telecommunication Implementation Guide versions ( ) were added to this documents. These questions include:

In section “Compounds/Multi-Ingredient Processing”, subsection “Compound Identifiers”,
“How do I enter an ingredient in a compound that does not have an identifier (for example water)?”

In section “Compounds/Multi-Ingredient Processing”, subsection “Partial Fill Compounds”, “How do I bill for a partial fill of a compound?”

In section “Reversal Transactions”, subsection “Multiple Claim/Service Reversal Transactions Within a Transmission”, “What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?”

In section “Rebill Transactions (B3, C3, N3), subsection “Multiple Rebill Transactions in a Transmission”, “What are the recommended guidelines for supporting multiple rebill (B3, N3, C3) transactions within a transmission?”

In section “Response Segment Discussion”, subsection “Response Pricing Segment”, subsection “Captured Response”, “Why would the Response Pricing segment be used (optional) in a Billing transaction (or other transaction) when a processor returns a “C”aptured response?”

VERSION 9.Ø

“Appendix E. Where Do I Find” has been added, with a reference in section “General Questions”.

VERSION 1Ø.Ø

In section “Pricing Segment”, subsection “Sales Tax Fields”, the subsection “Format” was added with the question “How is the format of Percentage Sales Tax Rate Submitted (483-HE) and Percentage Sales Tax Rate Paid (56Ø-AY) expressed?”

In section “Transmission/Transaction Syntax”, subsection “Field Truncation”, a subsection “Truncation of Numeric Fields” was added with the question “In the Telecommunication Standard, a field such as Patient Location (3Ø7-C7) is defined as a two-byte numeric with values 1-11. Can I send the leading zeroes in values 1-9 (meaning sending Ø1, Ø2, Ø3..., or 1, 2, 3)?” Also the subsection “Printable Characters”, subsection “Usage” was added with the questions “What are printable characters?”, and “Can characters, i.e.: alpha, numeric and symbols (if allowable) be separated by spaces?”.

In section “Transaction Discussion”, a subsection “Eligibility Transaction”, subsection “Group Separator” was added with the question “The Telecommunication Standard Implementation Guide 5.1 on page 2 it states that "A transmission consists of one or more transactions separated by group separators….”

In section “Compound/Multi-Ingredient Processing”, a subsection “Reversal Transaction”, subsection “Use of Product/Service ID (4Ø7-D7) and Compound Code (4Ø6-D6) was added with the question “On a compound billing the Product/Service ID field (4Ø7-D7) on the Claim Segment will have a default value of zero and the NDCs for the compound ingredients will come in on the Compound Segment in the Compound Product ID field (489-TE)….”

In section “Request Segment Discussion”, subsection “Insurance Segment”, a subsection was added “Cardholder ID (3Ø2-C2)” with the question “Can a cardholder ID contain symbols such as hyphens and apostrophes?”

VERSION 11.Ø

A need was defined to relay the Discharge Date of a patient from a hospital setting. Since this need had to be met in the Telecommunication Standard Version 5.1 and the Batch Standard Version 1.1 environment, the membership decided to use the Prior Authorization Number Submitted (462-EV) until a long-term solution was found. See section “Claim Segment”, subsection “Discharge Date Support”, “Usage”.

In section “Claim Segment“, subsection “Fill Number (4Ø3-F3)”, a new subsection was added, “Default?”.

In section “Transmission/Transaction Syntax”, subsection “Rejecting Transactions”, the section “Invalid Version/Release Number (1Ø2-A2), Transaction Code (1Ø3-A3), or Transaction Count (1Ø9-A9)” was added.

In section “Prior Authorization Transaction” subsection “Prior Authorization Request And Billing Transaction”, two sections were added – “P/A Request And Billing – PA Not Required” and “P/A Request And Billing – Deferred”.

In section “Editorial Changes Applicable To All Version 5 Data Dictionaries”, subsection “Corrections”, a section “Appendix F – Version 5.Ø Reject Codes For Telecommunication Standard” has been added.

In section “Claim Segment”, subsection “Coordination of Benefits” a new section “Other Coverage Code (3Ø8-C8)” has been added.

The section “Use Of This Document” has been added to the “Purpose Of This Document” section.

VERSION 12.Ø

In section “Pricing Segment”, subsection “Sales Tax Fields”, subsection “Usage”, the response to the question “How are the Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Percentage Sales Tax Rate Submitted (483-HE), and Percentage Sales Tax Basis Submitted (484-JE) used?” has been changed. The original response noted that both flat and percentage fields should not be used in a claim. However, upon further review, the membership felt tax situations that were based on flat and percentage sales tax was possible.

In section “Pricing Segment”, a new subsection “Usual And Customary Charge (426-DQ) Definition” has been added with the question “Does Usual And Customary Charge (426-DQ) include a dispensing fee?”

In section “Pricing Guidelines”, subsection “1ØØ% Copay”, a subsection was added “100% Copay and Negative Amounts” with the question “Under what situation would a Total Amount Paid (5Ø9-F9) be sent to the pharmacy with a negative dollar amount?”

In this same section, a subsection has been added “Payment Amount Based on Dispensed or Intended?” with the question “Do NCPDP standards require the payment amount to be based on the amount actually dispensed, or can the intended amount be used instead?”

In section “Claim Segment”, subsection “Coordination of Benefits” a new section “Other Coverage Code (3Ø8-C8)” has been clarified further. Please note these changes from the previous version.

In section “COB/Other Payments Segment”, a new subsection “Other Payer Amount Paid Count (341-HB)”, subsection ”Reject Code When Count Does Not Match” has been added with the question “What Reject Code (511-FB) should be used when the Other Payer Amount Paid (431-DV) doesn’t match the number submitted in the Other Payer Amount Paid Count (341-HB)?” A subsection was added “Other Payer Amount Paid Count and Other Payer Reject Count for the same Other Payer”. A subsection was added “Negative Amounts”. A new subsection was added under Other Payer ID (34Ø-7C) of “Same Other Payer ID (34Ø-7C) In Different Coordination of Benefits/Other Payments Count (337-4C) Occurrences”.

In section “Pricing Guidelines”, a new subsection “Transaction Fee Charge” has been added with a question about a transaction fee paid by the pharmacy.

In section “Insurance Segment”, subsection “Facility ID (338-8C) a new question has been added “Does the field Facility ID (336-8C) link to a patient and an insurance plan? Is this field in any way linked or associated with a prescriber? How do you see this field being used in the real world? How would an insurance plan utilize this field?”

In “Appendix B. Coordination Of Benefits Explanation For Version 5.1”, a new subsection “Questions”, subsection “Partial Fill” has been added with the question “How should Partial Fills be handled for a Coordination of Benefits (COB) billing? How does the reject of “Partial Fill Transaction Not Supported” affect this processing?”

VERSION 13.Ø

In section “Claim Segment”, subsection “Submission Clarification Code (42Ø-DK)”, subsection “Submission Clarification Code Count (354-NX)”, a new question “What Reject Code (511-FB) should be used when the Submission Clarification Code (42Ø-DK) doesn’t match the number submitted in the Submission Clarification Code Count (354-NX)?” has been added.

In section “COB/Other Payments Segment”, subsection “Other Payer-Patient Responsibility Amount Code (352-NQ) and Qualifier (351-NP)”, a new question “What Reject Code (511-FB) should be used when the Other Payer-Patient Responsibility Amount (352-NQ) and Qualifier (351-NP) doesn’t match the number submitted in the Other Payer-Patient Responsibility Amount Count (353-NR)?” has been added.

VERSION 14.Ø

In section “Claim Segment”, subsection “Procedure Modifier Code (459-ER)”, a new question has been added for “Procedure Modifier Code with NDC”.

In section “Compound/Multi-Ingredient Processing”, subsection “Quantity Dispensed (442-E7)”, a new question has been added for “Quantity Dispensed (442-E7) and Compounds”. A new question has been added for “Product Service ID Qualifier (461-E1) and Product Service ID (4Ø7-D7)”. A new question has been added for “Compound Ingredient Calculates to be Less than $Ø.ØØ5.”

In section “Field Truncation”, the subsection “Truncation of Dollar Fields” has been added.

In section “COB/Other Payments Segment”, a new question has been added for “Other Payer Coverage Type (338-5C) Value “99” (Composite) and Other Payer ID (34Ø-7C)”.

In section “Clinical Segment”, a question has been added for “Explicit Decimal Points in Diagnosis Code (424-DO)”.

A new section has been added of “NCPDP Batch Standards - Medicare-Related Questions”. Questions were received from Medicare, and about Medicare processing of pharmacy claims.

In “Appendix B. Coordination Of Benefits Explanation For Version 5.1”, a section for “Reporting Out of Pocket Expenses” has been added that points to the Medicare section for a standard solution to this reporting need. In section “Pricing Guidelines”, a subsection for “Patient Paid Amount Submitted (433-DX)” has been added that discusses the use of this field for intended or actual amounts, and uses the same recommendation as the out of pocket expenses.

APPENDIX A. TYPOGRAPHICAL CHANGES MADE IN VERSION 6.Ø

Segment	**Transaction Example V5.1**	Field Number	Field Name	Correction	Description of Change
Capture response	7.14.1				Change Pricing Segment to only have copays.
Request Claim Segment	various examples	415-DF	Number of Refills Authorized	Presentation method	Field is 9(2). In examples, show the field as zero suppressed. (In some examples, the leading zero is displayed.)
Response Status	7.2.5, 7.3.2, 7.4.2, 7.5.2, 7.7.2, 7.13.4, 7.14.1, 7.15.3, 7.18.2, 7.24.2	5Ø3-F3	Authorization Number		Auth Number is not mandatory for a reject response. Make Auth Number optional. Reject Count and Code are Mandatory. Use same "presentation" in each example.
Qualifiers	various examples and Segment Discussions		(Patient ID Qlfr, Prescriber ID Qlfr, Other Payer ID Qlfr, DUR Co-Agent ID Qlfr, Compound Ingred Basis of Cost Determination)	Presentation method	Field is x(2). In examples, consistently show the field appropriately. (In some examples, the leading zero is missing.)
Patient	7.2.	322-CN	Patient City Address	323-CN	Correct Field ID.
Pharmacy Provider	7.2.1	449-E9	Provider ID	444-E9	Correct Field ID.
Patient	7.2.1	322-CN	Patient City Address	323-CN	Correct Field ID.
Pharmacy Provider	7.2.1	466-EZ	Provider ID Qualifier	465-EY	Correct Field ID.
	7.2.1	449-E9	Provider ID	444-E9	Correct Field ID.
Insurance	7.3.	313-DC	Cardholder Last Name	313-CD	Correct Field ID.
Insurance	7.5.	313-DC	Cardholder Last Name	313-CD	Correct Field ID.
Response DUR/PPS	7.5.1	473-7E	DUR/PPS Response Code Counter	567-J6	Correct Field ID and Name (9 times).

Segment	**Transaction Example V5.1**	Field Number	Field Name	Correction	Description of Change
Patient	7.6.	322-CN	Patient City Address	323-CN	Correct Field ID.
DUR/PPS	7.6.	567-J6	DUR/PPS Code Counter	473-7E	Correct Field ID and Name in 2nd transaction.
Compound	7.7 Submission	449-EE	Compound Ingred Drug Cost	intentionally missing	Add a note that for this example, the value of this field was intentionally left off to show an error situation.
	7.7 Paid/Captured Response				Denote that in the Paid/Captured response, that this assumes the drug cost was submitted without the error.
	7.7 Rejected Response	546-4F	Reject Occurrence	Should be 1	Drug Cost missing on ingredient 1, not 3
Compound	7.7 section			optional segment denotation	Denote the Compound Segment as optional. Denote the optional designation of the last two fields in the Cmpd Segment on each iteration.
Compound	7.7.2				
Patient	7.8.	322-CN	Patient City Address	323-CN	Correct Field ID.
Response Pricing	7.8.1	558AW	Flat Sales Tax Amount Paid	558-AW	Add dash to Field ID.
Patient	7.9.	322-CN	Patient City Address	323-CN	Correct Field ID.
Pharmacy Provider	7.9.	449-E9	Provider ID	444-E9	Correct Field ID.
Pharmacy Provider	7.9.	466-EZ	Provider ID Qualifier	465-EY	Correct Field ID.
Pricing Segment	7.11	412-DC	Dispensing Fee Submitted		Add 1ØØ{ in Value column.
Response Claim	7.14.1	557-AU	Preferred Product Description	556-AU	Correct Field ID.

Segment	**Transaction Example V5.1**	Field Number	Field Name	Correction	Description of Change
Patient	7.19.	322-CN	Patient City Address	323-CN	Correct Field ID.
Clinical	7.19.	949-ZE	Measurement Date	494-ZE	Correct Field ID.
Response Pricing	7.21.1	477-BE	Professional Service Fee Paid	562-J1	Correct Field ID.
Pharmacy Provider	7.22.	449-E9	Provider ID	444-E9	Correct Field ID.
Patient	7.22.	322-CN	Patient City Address	323-CN	Correct Field ID.
Patient	7.23.	322-CN	Patient City Address	323-CN	Correct Field ID.
Patient	7.24.	322-CN	Patient City Address	323-CN	Correct Field ID.
Response Status	7.24.2	459-7F	Help Desk Phone Number Qualifier	549-7F	Correct Field ID.
General review	all examples			optional segment denotation	Verify each example shows the segment as optional or mandatory by consistent nomenclature. Most segments are correct. Just verify.

Other Corrections:

Segment	**Transaction Example V5.1**	Field Number	Field Name	Correction	Description of Change
Transaction Response Status Segment	7.2.5, all examples			optional segment denotation	Moved Reject Count and Reject Code out of optional section into main section of segment.
Added note at end of example	7.7			added note	Note: In this example, the field 449-EE Cmpd Ingredient Drug Cost was intentionally not submitted to show a rejected situation. In the Reject Response, this error is noted. However, assume the field was submitted with value $1.2Ø for the Captured or Paid Responses below.
Added note at end of example	7.7.1			added note	Note: Assume in this example that the $1.2Ø Compound Ingredient Drug Cost was submitted and this is the payment or captured response.
Compound Segment, added note at end of example	7.7.2			added note	Remove the incorrectly denoted "The Following Fields are Optional:" from the Compound Segment notation. Noted the reject was intentional on the submission. *Noted in the Paid/Captured response that the example reflects the field being sent.* *Noted in the Rejected Response that this assumes the drug cost was missing. Changed the Reject Occurrence Indicator to 1 and changed comment to Tetracycline.*
Compound Segment	7.7.3			optional segment denotation	Compound Segment is optional. Per standard way of denoting segments in the imp guide, the statement "The following fields are optional:" was added, with the table split.
Pricing Segment	7.11	412-DC	Dispensing Fee Submitted	added value	Added the value of 1ØØØ to the Dispensing Fee Submitted Value column.
Response Claim Segment, Response Pricing Segment	7.14.1		Preferred Product fields, Payment fields	removed from segments	Removed the Preferred Product fields from the Response Claim Segment. Removed the payment fields from the Response Pricing Segment.

APPENDIX B. COORDINATION OF BENEFITS EXPLANATION FOR VERSION 5.1

The following sections were added to this Editorial document to assist the implementer in a consistent usage of Version 5.1 for Coordination of Benefits (COB).

Please also see section “Claim Segment”, subsection “Coordination of Benefits”, “Other Coverage Code (3Ø8-C8)” for information.

PHARMACY BILLS TO INSURANCE DESIGNATED BY PATIENT

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*610066*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*1234567890*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*20010313*	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	
INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*987654321*	Cardholder SSN

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*1234*	
3Ø3-C3	PERSON CODE	*3*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*3*	Child
CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	RX /SERVICE REF NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6094228*	Clinoril 2ØØmg
4 Ø8-D8	DISPENSE AS WRITTEN/PRODUCT SELECTION CODE	*2*	Patient has requested Brand

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	*557{*	$55.7Ø
412-DC	DISPENSING FEE SUBMITTED	*50{*	$5.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*707{*	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	*607{*	$6Ø.7Ø

423-DN	BASIS OF COST DETERMINATION	*Ø3*	Direct

PAYER REJECTS INDICATING OTHER COVERAGE EXISTS
and additionally provides some information about Other Payers

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT
5Ø 4-F4	MESSAGE	*OC: "Primary Name", "Primary Carrier Group Number", 8ØØ-888-8888*	Freeform message about Other Payer on file.

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected
51Ø-FA	REJECT COUNT	*1*	
511-FB	REJECT CODE	*41*	Submit Bill to Other Payer or Primary Payer
549-7F	HELPDESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELPDESK PHONE NUMBER	*6Ø2357Ø862*	
526-FQ	ADDITIONAL MESSAGE INFO	*For questions regarding primary coverage call... at nnn-nnn-nnnn.*	Additional message space if required.

PHARMACY BILLS TO OTHER INSURANCE

This occurs *after* pharmacy gets data from patient

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*999999*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*XYZ*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbb*	
INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*998877665*	Cardholder SSN

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*3451*	
3Ø3-C3	PERSON CODE	*4*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*3*	Child
CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	RX /SERVICE REF NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6Ø94228*	Clinoril 2ØØmg
4 Ø8-D8	DISPENSE AS WRITTEN/PRODUCT SELECTION CODE	*2*	Patient has requested Brand

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

Pricing fields submitted per rate for THIS payer.

4Ø9-D9	INGREDIENT COST SUBMITTED	*567{*	$56.7Ø
412-DC	DISPENSING FEE SUBMITTED	*45{*	$4.5Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	*7Ø7{*	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	*612{*	$61.2Ø
423-DN	BASIS OF COST DETERMINATION	*Ø1*	AWP

PRIMARY INSURANCE PAYS THE CLAIM

Included in the PATIENT PAY AMOUNT of $2Ø.ØØ is a Deductible Amount, a standard Copay and a Product Selection Amount.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1
RESPONSE INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*25*	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	*2316*	
568-J7	PAYER ID QUALIFIER	*1*	National Payer ID
569-J8	PAYER ID	*2223345678*	

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	
549-7F	HELPDESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELPDESK PHONE NUMBER	*8ØØ9986222*	
RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REF NUMBER	*1234567*	

The Following Fields are Optional:

551-9F	PREFERRED PRODUCT COUNT	*1*	1 Preferred product identified
552-AP	PREFERRED PRODUCT ID QUALIFIER	*Ø3*	NDC
553-AR	PREFERRED PRODUCT ID	*17236Ø56Ø1*	Ibuprofen 6ØØmg tablet

In this example, patient has requested the Brand Product (DAW = 2). This request will result in the processor adding the cost difference between the preferred and brand products to the Patient Pay Amount. Using the above fields, the processor provides information about the preferred alternative if customer wishes to change their mind.

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	*2ØØ{*	$2Ø.ØØ
5Ø6-F6	INGREDIENT COST PAID	*567{*	$56.7Ø
5Ø7-F7	DISPENSING FEE PAID	*45{*	$4.5Ø
5Ø9-F9	TOTAL AMOUNT PAID	*412{*	$41.2Ø
522-FM	BASIS OF REIMBURSE DETERMINATION	*1*	Ingredient Cost Paid as Submitted
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	*55{*	$5.5Ø
518-FI	AMOUNT OF COPAY/CO-INSURANCE	*12Ø{*	$12. ØØ
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	*25{*	$2.5Ø

Below are related definitions and examples from the NCPDP Data Dictionary:
5Ø5-F5 PATIENT PAY AMOUNT: Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.

517-FH AMOUNT APPLIED TO PERIODIC DEDUCTIBLE: Amount to be collected from a patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is applied to a periodic deductible.

Examples: A patient has a $5Ø.ØØ deductible to meet. The patient's first prescription costs $95.ØØ. The amount applied to the periodic deductible would reflect $5Ø.ØØ. This field would reflect: 5ØØ{.

A patient has a $1ØØ.ØØ deductible to meet. The patient has previously met $8Ø.ØØ of the deductible. The next prescription purchased costs $42.ØØ. The amount applied to the periodic deductible would reflect $2Ø.ØØ. This field would reflect: 2ØØ{.

518-FI AMOUNT OF COPAY/ COINSURANCE: Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to a per prescription copay/coinsurance.

Examples: If the patient's copay is $5.ØØ, but they have also met a deductible in the same transaction, this field may not be the same as the amount in field 5Ø5-F5. This field would reflect: 5Ø{.

519-FJ AMOUNT ATTRIBUTED TO PRODUCT SELECTION: Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to the patient's selection of drug product.

Examples: The patient chooses a brand drug instead of the generic. The plan design for the patient's benefit package requires that the patient must pay for the difference between the prescribed drug price and the preferred drug price. If the difference is $17.54, this field would reflect: 175D.

SCENARIO 1: PHARMACY BILLS SECONDARY INSURANCE

SUBMIT CLAIM INDICATING OTHER PAYER AMOUNT PAID

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*610066*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*1234567890*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*20010313*	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	
INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*987654321*	Cardholder SSN

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*1234*	
3Ø3-C3	PERSON CODE	*3*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*3*	Child

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	RX /SERVICE REF NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6094228*	Clinoril 2ØØmg
3Ø8-C8	OTHER COVERAGE CODE	*2*	Other coverage exists-payment collected
PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	*557{*	$55.7Ø
412-DC	DISPENSING FEE SUBMITTED	*5Ø{*	$5.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*7Ø7{*	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	*6Ø7{*	$6Ø.7Ø*
423-DN	BASIS OF COST DETERMINATION	*Ø3*	Direct

Billing for Contracted Rate of Secondary with Indication of Amount that has been Paid.

*** Definition of Gross Amt Due only allows for 'the sum of' selected fields as presented in the Pricing Segment. It does NOT allow for the "sum of" the fields *minus* Other Payer Amount Paid.**

COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø5*	COB SEGMENT

337-4C	COB/OTHER PAYMENTS COUNT	*1*	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	*Ø1*	Primary
339-6C	OTHER PAYER ID QUALIFIER	*Ø3*	Bin #
34Ø-7C	OTHER PAYER ID	*999999*	ID assigned to payer
443-E8	OTHER PAYER DATE	*2ØØ1Ø313*	March 13, 2ØØ1
341-HB	OTHER PAYER AMOUNT PAID COUNT	*1*	One occurrence
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	*Ø7*	Drug Benefit
431-DV	OTHER PAYER AMOUNT PAID	*412{*	$41.2Ø paid

SCENARIO 1: SECONDARY INSURANCE PAYS THE CLAIM
SUBMITTED WITH OTHER PAYER AMOUNT PAID

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1
RESPONSE INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*25*	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	*9988*	
568-J7	PAYER ID QUALIFIER	*1*	National Payer ID
569-J8	PAYER ID	*12121212*	
RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*11122233345678*	
549-7F	HELPDESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELPDESK PHONE NUMBER	*6Ø2357Ø862*	
RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REF NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	*5{*	$ØØ.5Ø Copay
5Ø6-F6	INGREDIENT COST PAID	*557{*	$55.7Ø
5Ø7-F7	DISPENSING FEE PAID	*5Ø{*	$5.ØØ
566-J5	OTHER PAYER AMOUNT RECOGNIZED	*412{*	$41.2Ø

5Ø9-F9	TOTAL AMOUNT PAID	*19Ø{*	$19.ØØ
522-FM	BASIS OF REIMBURSE DETERMINATION	*1*	Ingredient Cost Paid as Submitted

TOTAL AMOUNT PAID represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4) **less** 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).

NOTE: In above example, total reimbursement from Secondary provides a different result than total payment from Primary due to different contracted rates.

SCENARIO 2: PHARMACY BILLS SECONDARY INSURANCE
SUBMIT PATIENT PAY AMOUNT

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*61Ø066*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*1234567890*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2Ø1Ø313*	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	
INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*987654321*	Cardholder SSN

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*1234*	
3Ø3-C3	PERSON CODE	*3*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*3*	Child

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	RX /SERVICE REF NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6Ø94228*	Clinoril 2ØØmg
3Ø8-C8	OTHER COVERAGE CODE	*8*	Claim is a billing for a copay

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	*1*	1 occurrence
479-H8	OTHER AMOUNT CLAIMED SUBMITTED	*99*	Other

	QUALIFIER		
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	*2ØØ{*	$2Ø.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*7Ø7{*	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	*2ØØ{*	$2Ø.ØØ

In order for the NCPDP Version 5.1 to allow a COPAY ONLY billing, the above recommendation was adopted at the May 2ØØ1 Telecommunication Work Group. No Ingredient Cost or Dispensing fields are expected (however these could be submitted with zeros). This recommendation allows partners to stay in compliance to the definition of Gross Amount Due.

Other Amount Claimed Submitted will be the *entire* Patient Pay Amount. Until a later version of NCPDP Telecomm standard is allowed, "the pieces" of Patient Pay Amount cannot be billed.

A COB Segment was felt to be unnecessary so was excluded from example, but this *could be* used by trading partner agreement if Other Payer ID or Other Payer Date are required.

SCENARIO 2: SECONDARY INSURANCE PAYS THE CLAIM
SUBMITTED WITH PATIENT PAY AMOUNT

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1
RESPONSE INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*25*	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	*9988*	
568-J7	PAYER ID QUALIFIER	*1*	National Payer ID
569-J8	PAYER ID	*12121212*	
RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*11122233345678*	
549-7F	HELPDESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELPDESK PHONE NUMBER	*6Ø2357Ø862*	
RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	RX/SERVICE REF NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REF NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	*5{*	$ØØ.5Ø Copay
5Ø6-F6	INGREDIENT COST PAID	*~~ØØØ~~{*	$ØØ.ØØ or field not provided
5Ø7-F7	DISPENSING FEE PAID	*~~ØØØ~~{*	$ØØ.ØØ or field not provided
563-J2	OTHER AMOUNT PAID COUNT	*1*	Same as submitted
564-J3	OTHER AMOUNT PAID QUALIFIER	*99*	As submitted
565-J4	OTHER AMOUNT PAID	*2ØØØ*	$2Ø.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	*195{*	$19.5Ø
522-FM	BASIS OF REIMBURSE DETERMINATION	*~~Ø~~*	Ø or field not provided

Since no Ingredient Cost or Fees are submitted on a Copay Only billing, it is not expected that such would be returned. Expectation is that fields will be zero if present or field not present.

However, since OTHER AMOUNT SUBMITTED fields were detailed, recommendation is to supply the corresponding fields on the response. If a submitted amount is NOT being paid, indicate this with that payment amount of zero.

QUESTIONS

PARTIAL FILL

Question:
How should Partial Fills be handled for a Coordination of Benefits (COB) billing? How does the reject of "Partial Fill Transaction Not Supported" affect this processing?

Response:
Since there are many combinations (Primary accepts/does not accept Partial Fills/Primary does/does not do online COB, Secondary accepts/does not accept Partial Fills/Secondary does/does not do online COB), it is recommended that COB billing to the secondary (or downstream payer) should not occur until the pharmacy has determined the final resolution of the claim.

REPORTING OUT OF POCKET EXPENSES

See section "Medicare Crossover Claims", subsection "Support of Allowed Amount, Deductible Amount, Co-insurance Amount and Co-payment Amount" for information about reporting out of pocket expenses using Other Payer Amount Paid Qualifier (342-HC). This solution is to be used in situations of reporting out of pocket expenses in Version 5.Ø-5.4. In Version 5.5, the Other Payer-Patient Responsibility fields are to be used. The reporting of the out of pocket expenses is not a copay only situation, as the payer needs more than just out of pocket. The program needs to track dollars so they can create the out of pocket total. The program is not paying for copay only but also deductibles.

APPENDIX C. PRIOR AUTHORIZATION CLARIFICATIONS

The following lists the changes made to the Implementation Guide, Version 7.1, but which are applicable to all Version 5 and above guides, as the changes reflect clarifications to explain the prior authorization process. The sections affected in the Implementation Guide are 4.1.6, 4.2.12, 4.4.7, FAQ, and Examples.

4.1.5 PRIOR AUTHORIZATION (TRANSACTION CODES P1-P4)

(No change. Section shown for flow.)

Prior authorization transactions include Request and Billing, Reversal, Inquiry and Request Only. See the Usage Matrix in this document for required segments. Prior authorization transactions in Version 5 allow providers and payers to electronically communicate the need for and approval to dispense special situation medications. Only one transaction per transmission is permitted.

Prior Authorization reversals are used to reverse the request for authorization, but not any claims submitted against the prior authorization. To reverse a Prior Authorization Request and Billing, reverse the Prior Authorization Request and, if necessary, reverse the billing. The order of reversals may be determined by trading partners.

Change reflects section modification (in total).

4.1.6 PRIOR AUTHORIZATION FIELDS

Prior Authorization/Medical Certification Code and Number (Field 416-DG)

Versions 3.2—4.2 combined the Prior Authorization/Medical Certification Code and Number (Field 416-DG). Version 5 and above offers two fields to separately delineate this data.

The Prior Authorization Type Code (Field 461-EU) defines the type of authorization being requested.

The Prior Authorization Number Submitted (Field 462-EV) contains the value assigned to the authorization. Note: When/If the pharmacy submits a claim or service billing, the value of the field Prior Authorization Number - Assigned (498-PY) **from the processor's response** is placed in the Prior Authorization Number - Submitted (462-EV) on the claim or service billing transaction submission.

The Prior Authorization Number—Assigned (Field 498-PY) is used to communicate to the provider the Prior Authorization number assigned by the processor. This field is returned as part of the Prior Authorization Response Segment.

In addition, when performing a Prior Authorization Reversal (Transaction Code P2), this field contains the Prior Authorization Number the provider

is reversing. This field would be populated when reversing transaction with original responses of “P” (Paid) or “A” (Approved).

4.2.12 PRIOR AUTHORIZATION SEGMENT

Prior Authorization Supporting Documentation (Field 498-PP) is used to supply information not included in other data fields that may be required to process the prior authorization transaction.

When Request Type (498-PA) value of “2” (Reauthorization) is used, the Prior Authorization Number – Assigned (498-PY) is populated with the prior authorization number from the original request.

See the **Data Dictionary** for comments under each field for further clarification.

Change reflects section modification (in total).

4.4.7 RESPONSE PRIOR AUTHORIZATION SEGMENT

Please see the section “Prior Authorization Transaction Discussion”.

New section to be added to document, before Section 5.

PRIOR AUTHORIZATION TRANSACTION DISCUSSION

The Prior Authorization transactions have been created to allow a Processor to authorize, authorize and immediately adjudicate the claim or service, defer, or pend the request for review.

Prior Authorization before dispensing prescriptions may be required for (but not limited to) medical exceptions, drug overrides or limitations, or dosage limitations.

TRANSACTION USAGE

PRIOR AUTHORIZATION REQUEST AND BILLING

The pharmacy submits a Prior Authorization Request And Billing to receive approval for the Prior Authorization and to receive payment information. If the processor responds that the Prior Authorization Request and Billing is “P” (Paid) or “D” (Duplicate of Paid), the response will include a Prior Authorization Number- Assigned (498-PY), other pertinent information in the Response Prior Authorization Segment, and payment information in the Response Pricing Segment.

However, when a Prior Authorization Request And Billing receives a “C” (Captured) or “Q” (Duplicate of Capture) response the pharmacy system **will not** receive a Prior Authorization Number - Assigned (498-PY). The pharmacy would receive an

Authorization Number (5Ø3-F3) in the Response Status Segment to a “C” (Captured) or “Q” (Duplicate of Capture).

The pharmacy system ***may*** receive a Prior Authorization Number – Assigned (498-PY) with an “F” (Deferred) response, depending on the processor’s requirements. The pharmacy ***may*** receive an Authorization Number (5Ø3-F3) with an "F" (Deferred) response, depending on the processor’s requirements. On an “F” (Deferred), if the processor does not send a Prior Authorization Number – Assigned (498-PY), the pharmacy will receive an Authorization Number (5Ø3-F3) in the response. Later, when the pharmacy inquires about the prior authorization by using a Prior Authorization Inquiry, the value from the original transaction (Response Status Segment Authorization Number (5Ø3-F3)) would be placed in the request field Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

Chart 1

Prior Authorization Request And Billing				
Response	**PA Number Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**	**Response Prior Authorization Segment (Prior Authorization Information)**	**Response Pricing Segment (Payment Information)**
P-Paid **D- Duplicate Paid**	Yes	No	Yes	Yes
C-Captured **Q-Duplicate Captured**	No	Yes	Yes	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number – Assigned (498-PY) not sent	Yes	Yes
R-Rejected	No	Processor Defined**	No	No

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

PRIOR AUTHORIZATION REQUEST ONLY

The pharmacy submits a Prior Authorization Request Only to receive approval for a prior authorization, without any payment information.

A pharmacy’s Prior Authorization Request Only that is “A” (Approved) or “S” (Duplicate of Approved) should receive a response that includes a Prior Authorization Number-Assigned (498-PY) and other information in the Response Prior Authorization Segment. The pharmacy will not receive any payment information.

When a Prior Authorization Request Only receives a “C” (Captured) or “Q” (Duplicate of Capture) response, the pharmacy system **will not** receive a Prior Authorization Number

- Assigned (498-PY). The pharmacy would receive an Authorization Number (5Ø3-F3) in the Response Status Segment to a “C” (Captured) or “Q” (Duplicate of Capture).

The pharmacy system *may* receive a Prior Authorization Number – Assigned (498-PY) with an “F” (Deferred) response, depending on the processor’s requirements. On an “F” (Deferred) response, if the processor does not send a Prior Authorization Number – Assigned (498-PY), the pharmacy will receive an Authorization Number (5Ø3-F3) in the response. Later, when the pharmacy inquires about the prior authorization by using a Prior Authorization Inquiry, the value from the original transaction (Response Status Segment-- Authorization Number (5Ø3-F3)) would be placed in the request field Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

Chart 2

Prior Authorization Request Only				
Response	**PA Number Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**	**Response Prior Authorization Segment (Prior Authorization Information)**	**Response Pricing Segment (Payment Information)**
A-Approved S- Duplicate Approved	Yes	No	Yes	Yes
C-Captured Q-Duplicate Captured	No	Yes	Yes	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number – Assigned (498-PY) not sent	Yes	Yes
R-Rejected	No	Processor Defined**	No	No

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

PRIOR AUTHORIZATION INQUIRY

The pharmacy submits a Prior Authorization Inquiry to receive a status on a *previously submitted Prior Authorization Request And Billing* or *a previously submitted Prior Authorization Request Only*. A Prior Authorization Inquiry is submitted for a previously submitted Prior Authorization Request And Billing or Prior Authorization Request Only that was “C” (Captured).

The Prior Authorization Inquiry transaction supports multiple responses, but the responses are actually tied back to the originally requested transaction. The originally requested transaction is either a Prior Authorization Request And Billing or a Prior Authorization Request Only. The valid responses are the values applicable to either of those transactions.

If the initial request was a Prior Authorization Request And Billing that was not "P" (Paid) or "R" (Rejected) initially (meaning follow up was required) or a time out situation occurred, the subsequent Prior Authorization Inquiry would receive a response that was acceptable for the initial Prior Authorization Request & Billing - "P" (Paid), "C" (Captured), "F" (Deferred), or "R" (Rejected).

Chart 3

Fields Sent By a Pharmacy in a Prior Authorization Inquiry Based on the Response to the original Prior Authorization Request And Billing		
Original Response on the Prior Authorization Request And Billing	**PA Number Assigned (498-PY) in Prior Authorization Segment**	**Authorization Number (5Ø3-F3) in Prior Authorization Segment**
P-Paid	Yes	No
C-Captured	No	Yes
F-Deferred	Yes-if sent by processor	Yes-if sent by processor
R-Rejected Not applicable. There is no inquiry on a rejected PA Request and Billing		

Chart 4
Response to Chart 3.

Fields Returned by the Processor in a Prior Authorization Inquiry Response Based on the original PA Request And Billing		
Processor Response	**PA Number Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**
P-Paid or D-Duplicate of Paid	Yes	No
C-Captured or Q-Duplicate of Capture	No-unless the status of the original request has changed. Please see response according to result of adjudication of original request	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number – Assigned (498-PY) not sent
R- Reject	No	Processor Defined**

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

If the initial request was a Prior Authorization Request Only that was not approved or rejected initially (meaning follow up was required) or a time out situation occurred, the subsequent Prior Authorization Inquiry would receive a response that was acceptable for the initial Prior Authorization Request Only - "A" (Approved), "C" (Captured), "F" (Deferred), or "R" (Rejected).

Chart 5

Fields Sent in by Pharmacy in a Prior Authorization Inquiry Based on the Response to an original Prior Authorization Request Only		
Original Response on the Prior Authorization Request Only	**PA Number Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**
A-Approved	Yes	No
C-Captured	No	Yes
F-Deferred	Yes-if sent by processor	Yes-if sent by processor
R-Rejected Not applicable. There is no inquiry on a rejected PA Request and Billing		

Chart 6
Response to Chart 5.

Fields Returned by the Processor in a Prior Authorization Inquiry Response Based on the original PA Request Only		
Processor Response	**PA Number Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**
A-Approved	Yes	No
C-Captured	No-unless the status of the original request has changed. Please see response according to result of adjudication of original request	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number – Assigned (498-PY) not sent
R-Rejected	No	Processor defined**

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

PRIOR AUTHORIZATION REVERSAL

The Prior Authorization Reversal is used to back out the request for authorization, but not any claims submitted against the prior authorization. To reverse a Prior Authorization Request And Billing, paid billings should be reversed before the prior authorization is reversed. The pharmacy should submit a Claim or Service Reversal (Transaction Code = B2) before submitting a Prior Authorization Reversal request. If there are no Claims or Services paid for the Prior Authorization in question, the processor should accept the Prior Authorization Reversal for the prior authorization only. The only reversals that should be submitted would be for those transactions that received a “P” (Paid), “A” (Approved) or “C” (Captured) response.

The pharmacy would submit the Prior Authorization Number Assigned (498-PY) in the Prior Authorization Reversal for those transactions with original responses of “P” (Paid) or “A” (Approved) and the Authorization Number (5Ø3-F3) for those transactions with an original response of “C” (Captured).

FIELD CLARIFICATION

PRIOR AUTHORIZATION NUMBER - ASSIGNED (498-PY) IN RESPONSE PRIOR AUTHORIZATION *SEGMENT) AND AUTHORIZATION NUMBER (5Ø3-F3) IN RESPONSE STATUS*

SEGMENT

This section explains the usage of Prior Authorization Number – Assigned (498-PY) in the response returned by the processor, in a prior authorization situation.

For a Prior Authorization Request And Billing

The processor would return a Prior Authorization Number – Assigned (498-PY) in a “P” (Paid) or “D” (Duplicate of Paid) response.

For a Prior Authorization Request Only

The processor would return a Prior Authorization Number – Assigned (498-PY) in an “A” (Approved) or “S” (Duplicate of Approved) response.

For a Prior Authorization Request And Billing AND a Prior Authorization Request Only

The processor would return an Authorization Number (5Ø3-F3) in a “C” (Capture) or “Q” (Duplicate of Capture) response and **not** return a Prior Authorization Number – Assigned (498-PY). The Authorization Number (5Ø3-F3) would be used in a Prior Authorization Inquiry transaction to ask for the status of the prior authorization.

Some processors may return a Prior Authorization Number – Assigned (498-PY) in an “F” (Deferred) response. If Prior Authorization Number – Assigned (498-PY) is not returned, then Authorization Number (5Ø3-F3) must be returned.

Note: When/If the pharmacy submits a subsequent claim or service billing, the value of the field Prior Authorization Number - Assigned (498-PY) is placed in the in the Prior Authorization Number - Submitted (462-EV) on the claim or service billing transaction.

For a Prior Authorization Inquiry Only

Use the guidelines above depending on whether the initial transaction was a Prior Authorization Request And Billing, or a Prior Authorization Request Only.

A Prior Authorization Inquiry must be sent with a Prior Authorization Number - Assigned (498-PY) or Authorization Number (5Ø3-F3).

AUTHORIZATION NUMBER (5Ø3-F3) IN PRIOR AUTHORIZATION SEGMENT

This section explains the usage of Authorization Number (5Ø3-F3) in the request submitted by the pharmacy, in a prior authorization situation.

For a Prior Authorization Request And Billing AND a Prior Authorization Request Only

The Authorization Number (5Ø3-F3) is not needed for submission of a Prior Authorization Request And Billing OR a Prior Authorization Request Only.

For a Prior Authorization Inquiry Only

The Authorization Number (5Ø3-F3) would be submitted in a Prior Authorization Inquiry Only when the pharmacy was seeking a status for a previously sent Prior Authorization Request And Billing *or* Prior Authorization Request Only that received a “C” (Capture) or “Q” (Duplicate of Capture) response or a "F" (Deferred) response where the Prior Authorization Number Assigned (498-PY) was not returned.

For a Prior Authorization Reversal

The Authorization Number (5Ø3-F3) is supported in a submission of a Prior Authorization Reversal for "C" (Capture) responses only.

PRIOR AUTHORIZATION NUMBER-ASSIGNED (462-EV) IN CLAIM SEGMENT

This field is used only in transaction activities for claims and services associated with an approved Prior Authorization request. It is **NOT** used in a Prior Authorization Request And Billing or a Prior Authorization Request Only since the pharmacy is only seeking an approval.

When the pharmacy submits a claim or service billing for which a Prior Authorization has been granted, the Prior Authorization Number-Assigned (462-EV) should be submitted with the transaction in the Claim Segment. Likewise, should the provider submit a reversal of a paid claim or service billing (in which payment was predicated on an approved Prior Authorization), the Prior Authorization Number-Assigned (462-EV) should be submitted with the transaction in the Claim Segment.

The Prior Authorization Number Submitted (462-EV) on the claim or service billing should contain the value from the Prior Authorization Number – Assigned (498-PY) in the Response Prior Authorization Segment that was returned from the processor in the Prior Authorization Request And Billing OR the Prior Authorization Request Only. The Prior Authorization Number – Assigned (498-PY) would have been returned with a “P” (Paid) or “D” (Duplicate of Paid) response or with an “A” (Approved) or “S” (Duplicate of Approved) response.

SCENARIO EXAMPLES

The following illustrates a couple of the transaction scenarios discussed above, shown in tabular format. Treat each as a completely separate case.

PRIOR AUTHORIZATION REQUEST AND BILLING RESPONSES

The pharmacy requests a Prior Authorization Request And Billing (seeking approval and payment information). The following choice of responses would be sent by the processor.

- The processor responds with a “P” (Paid) or “D” (Duplicate of Paid) response. The payment information is included in the Response Pricing Segment. The Prior Authorization Number – Assigned (498-PY) and pertinent prior authorization information is returned in the Response Prior Authorization Segment.

Or

- The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response. The processor is still evaluating the prior authorization. The processor includes an Authorization Number (5Ø3-F3) in the response. The pharmacy will later submit a Prior Authorization Inquiry with the Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

Or

- The processor responds with a “F” (Deferred) response that includes a Prior Authorization Number – Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor’s provider manual for further information.

Or

- The processor responds with a “R” (Rejected) response, the pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the Prior Authorization Request And Billing.

Scenarios for Prior Authorization Request And Billing

1. The pharmacy requests a Prior Authorization Request And Billing (seeking approval and payment information).
   The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response that includes an Authorization Number (5Ø3-F3).
   The pharmacy later submits a Prior Authorization Inquiry with the Authorization Number (5Ø3-F3) in the Prior Authorization Segment.
   The processor has completed it's evaluation of the original request and responds with a “P” (Paid) or “D” (Duplicate of Paid) response. The payment information is included in the Response Pricing Segment. The Prior Authorization Number – Assigned (498-PY) and pertinent prior authorization information are returned in the Response Prior Authorization Segment.

Or

The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response. The processor is still evaluating the prior authorization. The pharmacy will later submit another Prior Authorization Inquiry with the Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

If the processor responds with another “C” (Captured) (or “Q” (Duplicate of Capture)) response, the same Authorization Number as the original would be returned to the pharmacy. The processor should not return a new Authorization Number (5Ø3-F3).

Or

The processor has completed its evaluation of the original request and responds with an “F” (Deferred) response that includes a Prior Authorization Number – Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor’s provider manual for further information.

Or

The processor has completed its evaluation of the original request and responds with an “R” (Rejected) response. The pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the original Prior Authorization Request And Billing.

2. The pharmacy submits a Prior Authorization Request And Billing (seeking approval and payment information.)
   The processor responds with a “P” (Paid) or “D” (Duplicate of Paid). The payment information is included in the Response Pricing Segment. The Prior Authorization Number – Assigned (498-PY) and pertinent prior authorization information is returned in the Response Prior Authorization Segment.
      To reverse the claim or service billing, the pharmacy submits a Claim or Service Reversal with the Prior Authorization Number – Submitted (462-EV) in the Claim Segment.
         The processor responds with an “A” (Approved) or “S” (Duplicate of Approved) and backs out the payment.
            To reverse the prior authorization, the pharmacy submits a Prior Authorization Reversal with the Prior Authorization Number – Submitted (462-EV) in the Claim Segment.
               The processor responds with an “A” (Approved) or “S” (Duplicate of Approved) and backs out the authorization only.

      *Note if claim reversal has not been initiated by the pharmacy, the Prior Authorization Reversal request would receive an “R” (Rejected) response

by the processor. The pharmacy should reverse the paid billings before requesting a prior authorization reversal.

3. The pharmacy submits a Prior Authorization Request And Billing (seeking approval and payment information.)
   The processor responds with a “P” (Paid). The payment information is included in the Response Pricing Segment. The Prior Authorization Number – Assigned (498-PY) and pertinent prior authorization information is returned in the Response Prior Authorization Segment. However, a timeout occurs and the pharmacy does not receive the prior authorization/payment response.
      The pharmacy must submit the same Prior Authorization Request And Billing transaction. (The pharmacy did not receive an Authorization Number (5Ø3-F3) since there was a timeout and therefore cannot send a Prior Authorization Inquiry to learn the status.)

PRIOR AUTHORIZATION REQUEST ONLY RESPONSES

The pharmacy requests a Prior Authorization Request Only (seeking approval, no payment information). The following choice of responses would be sent by the processor.

- The processor responds with an “A” (Approved) or “S” (Duplicate of Approved) response, with a Prior Authorization Number – Assigned (498-PY) given.

  Note: When/If the pharmacy submits a claim or service billing, the value of the field Prior Authorization Number - Assigned (498-PY) returned from the processor is placed in the Prior Authorization Number - Submitted (462-EV) on the claim or service billing transaction submission.

Or

- The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response. Note, the Prior Authorization Number - Assigned (498-PY) is not returned (this field is not applicable in a capture). The Authorization Number (5Ø3-F3) is returned by the processor.

Or

- The processor responds with a “F” (Deferred) response that includes a Prior Authorization Number – Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor’s provider manual for further information.

Or

- The processor responds with a “R” (Rejected) response, the pharmacy should examine the reject codes and messages. The transaction may

include missing/invalid information, or the processor may be denying the Prior Authorization Request Only.

Scenarios for Prior Authorization Request Only

1. The pharmacy submits a Prior Authorization Request Only (only seeking approval, not payment information).
   The processor responds with an “A” (Approved) or “S” (Duplicate of Approved) response, with a Prior Authorization Number – Assigned (498-PY) given. However, a timeout occurs and the pharmacy does not receive the prior authorization response.
   The pharmacy must submit the same Prior Authorization Request Only transaction. (The pharmacy did not receive an Authorization Number (5Ø3-F3) since there was a timeout and therefore cannot send a Prior Authorization Inquiry to learn the status.)

2. The pharmacy submits a Prior Authorization Request Only (only seeking approval, not payment information).
   The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response. Note, the Prior Authorization Number - Assigned (498-PY) is not returned (this field is not applicable in a capture). The Authorization Number (5Ø3-F3) is returned.
   The pharmacy later submits a Prior Authorization Inquiry with the Authorization Number (5Ø3-F3).
   The processor has completed its evaluation of the original request and responds with an “A” (Approved) or “S” (Duplicate of Approved) response. The Prior Authorization Number - Assigned (498-PY) along with other important information is returned.

   Or

   The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response. The processor is still evaluating the prior authorization. The pharmacy will later submit another Prior Authorization Inquiry with the Authorization Number (5Ø3-F3). The same Authorization Number as the original would be returned to the pharmacy. The processor should not return a new Authorization Number (5Ø3-F3).

   Or

   The processor has completed its evaluation of the original request and responds with an “F” (Deferred) response that includes a Prior Authorization Number – Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor’s provider manual for further information.

   Or

The processor has completed its evaluation of the original request and responds with an “R” (Rejected) response. The pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the original Prior Authorization Request Only.

3. The pharmacy submits a Prior Authorization Request Only (only seeking approval, not payment information).
   The processor responds with a “C” (Captured) or “Q” (Duplicate of Capture) response. Note, the Prior Authorization Number - Assigned (498-PY) is not returned (this field is not applicable in a capture). The Authorization Number (5Ø3-F3) is returned.
      To reverse the prior authorization, the pharmacy submits a Prior Authorization Reversal with the Authorization Number (5Ø3-F3). This is to reverse the prior authorization only no paid billings have been made.
   The processor responds with an “A” (Approved) or “S” (Duplicate of Approved) and backs out the Prior Authorization Request Only.

NEW FREQUENTLY ASKED QUESTIONS

Q: The initial transaction is a Prior Authorization Request Only. The pharmacy submits a Prior Authorization Inquiry for a status. What is the difference between a Prior Authorization Inquiry response of “C” (Capture) and “A” (Approved)?

ANS: A Capture response says the processor is still evaluating the original Prior Authorization Request Only. An approved response says the original Prior Authorization Request Only is approved and the response will include the Response Prior Authorization Segment information to be used in future transactions.

Q: Once the Prior Authorization Number is assigned, on subsequent refills, can you just submit the Prior Authorization in the Prior Authorization Number Submitted field in the Claim Segment, or do you need to keep sending the P/A segment with the P/A value in the Prior Authorization Number Assigned field?
Or do both segments need to contain the P/A?
When would you send the P/A number in the Claim segment only? Only when it is not obtained electronically or once it was obtained electronically?

ANS: For claim or service billing transactions (including refills), once a Prior Authorization Number – Assigned (498-PY) has been granted, the value returned by the processor in this field (Prior Authorization Number – Assigned (498-PY) (of the Response Prior Authorization Segment)) should be sent in the Prior Authorization Number – Submitted (462-EV) (in the Claim Segment) on each claim or service billing.

Q: Will each different ‘C’ Captured response of a *‘P/A Inquiry’* transaction come back with a unique Authorization Number (5Ø3-F3) or does it come back with the same one each time regardless of how many times you submit the ‘P/A Inquiry’ transaction and receive responses?
Another way of asking this question is:

Do you use the original Authorization Number from the *first* 'C' Captured response from the *'Request and Billing'* transaction over and over again if you keep sending 'P/A Inquiry' transactions, or would you send an Authorization Number from the *most recent 'P/A Inquiry'* transaction response on the 'P/A Inquiry' transactions?

ANS: The processor should return the same Authorization Number (5Ø3-F3) in a Capture situation. The pharmacy should submit the same Authorization Number (5Ø3-F3) on each Prior Authorization Inquiry for that Captured transaction.

EXAMPLE CHANGES

The following examples were modified to present correct models for Prior Authorization transactions.

7.16 PA Request and Billing – Transaction Code P1
Added blurb:
This is an initial request for prior authorization approval with payment information. Prior Authorization Segment contains the requested period dates.
Removed Prior Authorization Number – Assigned (498-PY) from table.

7.16.2 P/A Request & Billing Accepted Response – Paid
Added blurb:
The pharmacy receives prior authorization and payment information in the response.

7.16.3 P/A Request & Billing Rejected Response
Added blurb:
The pharmacy receives the response from the processor that the product or service is not covered. The preferred product information is returned. A Help Desk number is available for follow up questions.

7.16.4 P/A Request & Billing Duplicate Response
Added blurb:
The pharmacy receives a duplicate paid response. The information is the same as 7.16.2.

7.17 P/A Reversal – Transaction Code P2
Added blurb:
The pharmacy wishes to reverse the prior authorization that was previously processed. This is a request to reverse just the prior authorization. If claim or service billings were billed with this prior authorization, the claim or service billings would need to be reversed first; then the prior authorization reversed.
Removed the Claim Segment because the claims are to be reversed separately.

7.17.1 P/A Reversal Accepted Response – Captured, Approved
Removed the Response Claim Segment because the claims are to be reversed separately.

7.18 P/A Inquiry – Transaction Code P3
Added blurb:

New scenario. The pharmacy has submitted a PA Request And Billing sometime in the past, and received a captured response. The pharmacy is now submitting a PA Inquiry to determine the outcome, using the Authorization Number (5Ø3-F3) received during the PA Request And Billing conversation.
Removed all fields from PA Segment except Segment ID, Request Type, Request Period Begin and End, and Auth Number.

7.18.1 P/A Inquiry Accepted Response – Captured
Added blurb:
The original PA Request And Billing received a “C” Captured response. The pharmacy submits an inquiry as to the status. The processor is still evaluating the original PA Request And Billing and sends a “C” Captured response back to the pharmacy.

Also, the Authorization Number (5Ø3-F3) returned on the Captured response is the same as submitted (9876545678) per section 4.5.3.1.1 Scenarios for Prior Authorization Request And Billing.

7.18.2 P/A Inquiry Accepted Response – Paid
The processor is responding that the original PA Request And Billing has been approved and payment information is included. The processor assigns an Authorization Number to conversation. The processor returns payment, as well as prior authorization information, including a Prior Authorization Number – Assigned (498-PY).

7.19 P/A Request Only – Transaction Code P4
Added blurb:
New scenario. The pharmacy is requesting a prior authorization approval only (no payment). The Prior Authorization Segment includes the prior authorization period date and other information.

7.19.1 P/A Request Only Accepted Response –Approved
Added blurb:
The processor responds that the request for prior authorization has been approved, with appropriate prior authorization information.
Removed Capture from the heading and the Transaction Response Status and Note. Keep 498-PY.

7.19.2 P/A Request Only Rejected Response
Added blurb:
The processor is not approving the request for a prior authorization, as the product is not covered.

APPENDIX D. BILLING FOR COMPOUNDS

The following sections begin at section 4.2.1.5 of the Version 5.6 Implementation Guide. The information can be used with the Version 5 and above implementations as this is only clarifying information and does not change the specifications. See also the section "Compound/Multi-Ingredient Processing".

TWO OPTIONS TO DESIGNATE A COMPOUND

RECOMMENDED OPTION - OPTION 1 – USING THE CLAIM AND COMPOUND SEGMENTS

A Compound may be submitted using the Compound segment with multiple iterations of the Compound Product ID Qualifier, Compound Product ID and other repeating fields – one iteration for each ingredient in the compound. This transaction allows the pharmacy to submit any/all of the ingredients included in the preparation of the compound. This process is described in paragraph one of this section. (4.2.11). Option 1 is the recommended option.

Advantages:

- Ability to perform DUR.
- Ability to claim manufacturers rebates for all ingredients
- Ability to minimize rebate disputes.
- Ability to perform accurate pricing per ingredient.

ALTERNATE OPTION - OPTION 2 – USING THE CLAIM SEGMENT

A Compound may also be submitted using the Claim Segment without submitting the Compound segment. Option 1 above is the **recommended** option.
This can be accomplished by using one of the following scenarios:

Scenario A (Most expensive legend drug):
Submit a compound entering a 2 in the Compound Code (field 4Ø6-D6).
Submit the Product/Service ID (NDC for example) of the most expensive legend drug (field 4Ø7-D7).
Enter the sum of all the individual quantities as Quantity Dispensed (field 442-E7).
Enter the sum of all ingredient costs in the Ingredient Cost Submitted (field 4Ø9-D9).

Scenario B (Billing codes):
Using the values listed below in the Claim Segment, Product/Service ID (Field 4Ø7-D7) for submission, by trading partner agreement, of the most expensive ingredient for compound ingredient claims.

The Compound prescription claims may continue to use the following billing code values for legend and/or scheduled drugs:

Legend, non-scheduled	99999999999
Schedule II	99999999992

Schedule III	99999999993
Schedule IV	99999999994
Schedule V	99999999995
Miscellaneous compounds	99999999996

Either scenario of Option 2 may be used when trading partners do not support multiple-ingredient billing.

APPENDIX E. WHERE DO I FIND

ANSWERS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

- Telecommunication Standard Version 5.1
- Telecommunication Implementation Guide Version 5.1
- Data Dictionary
- Telecommunication Version 5 Questions, Answers, and Editorial Updates (the "Editorial" document)
- Protocol For Version 5.1 (the "Protocol" document) – in draft status

ADDITIONAL INFORMATION MAY BE FOUND IN THE FOLLOWING DOCUMENTS

Telecommunication Standard and Implementation Guide Version 5.2 and above

Although the usage of new fields or field changes in Version 5.2 and above is not allowed in the implementation of Version 5.1, the Version 5.2 and above documents may provide additional clarification, as additional verbiage has been added (COB, Prior Authorization, et cetera). This verbiage is usually included in the Version 5 Editorial document.

PARTICULAR TOPICS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

WHAT TRANSACTIONS ARE SUPPORTED FOR WHAT BUSINESS PURPOSES?

Transaction Discussion
Section 6 of Specifications
Transaction Types
Section 7 of Specifications
Special Considerations - Transactions, Segments, and Fields
Section 4 of Implementation Guide

WHAT FIELDS CHANGED?

Old Field Name Cross Reference
Section V of Data Dictionary
New Field Name Cross Reference
Section VI of Data Dictionary
Deleted Data Elements Not Supported in Version 5
Section VII of Data Dictionary

WHICH FIELDS ARE ALLOWED IN WHICH SEGMENTS?

Request and Response Quick Reference
Section 5 of Implementation Guide

WHERE DO THE SEGMENTS BELONG?

Segment Usage Matrix
Section 3 of Implementation Guide
Transmission Request Diagrams
Section 1Ø of Specifications
Transmission Response Diagrams
Section 12 of Specifications

WHAT ARE THE VALID RESPONSES FOR EACH TRANSMISSION?

- Transmission Response Discussion
  - Section 11 of Specifications
- Response Segment Matrices
  - Section 3 of Implementation Guide
- Response Transactions
  - Section 4 of Implementation Guide

RECOMMENDED USE OF DOLLAR FIELDS AND CALCULATED AMOUNTS?

- Special Considerations - Transactions, Segments, and Fields
  - Section 4 of Implementation Guide
- Frequently Asked Questions
  - Section 8 of Implementation Guide

EXPLAIN THE SYNTAX RULES FOR VERSION 5

- Document Conventions
  - Section 8 of Specifications
- Generally Accepted and Common Practices
  - Section 2 of Implementation Guide

COUNT AND COUNTER FIELDS – EXPLANATION AND USAGE?

- Repetition and Multiple Occurrences
  - Section 8 of Specifications
  - Examples
    - Billing W/ Insurance COB - Transaction Code B1, Section 7 of Implementation Guide
  - Examples
    - Billing W/ Submitted DUR Override - Transaction Code B1, Section 7 of Implementation Guide
  - Examples
    - Compounded Rx Billing - Transaction Code B1 (Ø1), Section 7 of Implementation Guide
  - Frequently Asked Questions
    - Section 8 of Implementation Guide

WHAT HAS CHANGED IN VERSION 5.1, 5.2, ET CETERA?

- Appendix A
  - Section 13 of Specifications
- Version Changes
  - Section 9 of Implementation Guide
- Version Modifications
  - Section M of Data Dictionary

WHAT IF I HAVE A NEW QUESTION?

- Send the question to NCPDP Council Office at ncpdp@ncpdp.org